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ABSTRACT

This document provides witness testimonies and prepared statements from the Congressional hearing called to examine the issue of adolescent pregnancy. Opening statements are given by Congressmen Henry A. Waxman, Robert Carcia, James Scheuer, and James V. Hansen. Witnesses include William Butz and Martin O'Connell from the Bureau of the Census who provide a statistical profile of teenagers developed from Census Bureau data. Wendy Baldwin from the National Institute for Child Health and Human Development discusses trends and correlates of adolescent pregnancy and childbearing. Jacqueline Darroch Forrest from the Alan Guttmacher Institute describes a study on teenage pregnancy and fertility in developed countries. Martha R. Burt from the Urban Institute considers effective interventions in the area of teenage pregnancy and parenting. Ronald D. Soloway from the Center for Public Advocacy Research addresses the policy and program implications of data provided by other witnesses; outlines steps in public policy to reduce teenage pregnancy by providing quality health and contraceptive services and by strengthening families; and considers policy and program expenditures in the areas of education, health, employment, family support, and child care. Also included are the results of a hearing on religious perceptions about family planning and sex education, a prepared statement from Congresswoman Cardiss Collins, and a paper on Hispanic teenagers from the Alan Guttmacher Institute. (NRB)

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DEMOGRAPHICS OF ADOLESCENT PREGNANCY IN THE UNITED STATES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON
CENSUS AND POPULATION

OF THE

COMMITTEE ON
POST OFFICE AND CIVIL SERVICE

AND THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

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DEMOGRAPHICS OF ADOLESCENT PREGNANCY IN THE UNITED STATES

TUESDAY, APRIL 30, 1985

HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON CENSUS AND POPULATION, OF THE COMMITTEE ON THE POST OFFICE AND CIVIL SERVICE, AND SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE,

Washington, DC.

The subcommittees met, pursuant to call, at 2:10 p.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the Subcommittee on Health and the Environment) presiding.

Mr. WAXMAN. The committee will please come to order.

Today's hearings are to examine the rates of adolescent pregnancy and the problems that teenage pregnancy and motherhood pose for mothers, families, and society. We will hear testimony about rates of fertility, of pregnancy, and of childbirth.

As we receive this testimony, however, I want to emphasize that there is another side of the issue that must be of great concern to the Congress—the health implications of young girls becoming pregnant:

> The maternal death rate for young teen mothers is more than twice that for mothers in their twenties.
>
> The infant mortality rate is almost twice as high.
>
> School-age mothers are far more likely to have babies that are premature or of low birth weight.
>
> And almost half of all teenage pregnancies end in abortion.

I think that all of us can agree that these numbers are unacceptably high.

In today's hearings, I hope that we can find clues about ways to lower the Nation's adolescent pregnancy rates and ways to help teenage mothers and their children live healthy and full lives.

We already know that some things work.

Family planning works, if only we can make services available.

Prenatal care works, if only we can make services available.

And infant health care works, if only we can make services available.

With so few resources available to lower pregnancy rates, lower infant mortality rates, and improve maternal and child health, we must be able to focus on preventive strategies for populations at high risk.

I hope that the trends that witnesses identify will point us toward efforts that must be begun and people most in need.

Before recognizing our witnesses, I want to call on our very distinguished colleague, Congressman Robert Garcia, who initiated these hearings, and who has shown a very special interest in the whole question of teenage pregnancy and what the appropriate response by Government should be.

Mr. Garcia.

Mr. **Garcia**. Thank you, Mr. Chairman.

I'd like to welcome everybody to the joint hearings of the Subcommittee on Census and Population and the Subcommittee on Health and the Environment, which is chaired by my distinguished colleague from California, Congressman Waxman.

This hearing, sponsored jointly by the Subcommittee on Census and Population and the Subcommittee on Health and the Environment will be on the demographics of adolescent pregnancy.

As most of you know, the incidence of adolescent pregnancy has reached epidemic proportions in the United States, and, according to a recent study, the rate of adolescent pregnancy in the United States is more than twice that of any other developed country in the Western world.

I believe that Government should commit itself to taking the necessary steps to radically reduce the incidence of adolescent pregnancy throughout the country.

Recently, I introduced legislation which, if approved, would significantly reduce the incidence of teenage pregnancy.

Over the past few years, we have approved piecemeal legislative solutions to address this broad problem. However, up to now, we have yet to devise a comprehensive Federal strategy to address this national problem.

My bill, H.R. 947, the Comprehensive Adolescent Pregnancy Amendment Act of 1985, creates and consolidates many programs to combat adolescent pregnancy.

Nevertheless, before we move any further in addressing this problem, I believe that we should gain a better understanding of the many variables surrounding it.

We will hear testimony from a host of expert witnesses on the following topics as they relate to adolescent pregnancy—a statistical overview, data on race and ethnic backgrounds, economic and educational data, regional profiles, past and future trends, as well as international comparisons.

Again, this hearing is the first step toward gaining a better understanding and possibly gain new insight into the problem of adolescent pregnancy.

Again, I thank my chairman, Mr. Waxman, for calling these joint hearings.

Mr. **Waxman**. Thank you, Mr. Garcia, and we're pleased that we are holding a joint hearing of our two subcommittees, the Subcommittee on Census and Population and our Subcommittee on Health and the Environment. We want to know what's going and what are the trends and what Government efforts would be appropriate.

Whenever we deal with population questions, however, we're pleased that on our subcommittee we have one of the leading experts in the country. Congressman Scheuer chaired a Select Committee on Population and has made this a very important field of expertise for himself in his career in Congress, and I'm pleased he's with us.

I'd like to call on Mr. Scheuer for any opening statements he wishes to make.

Mr. SCHEUER. Thank you very much, Mr. Chairman. I appreciate your kind words.

I do chair a congressional caucus on population and development under the umbrella of the Arms Control and Foreign Policy Caucus, and I also chair a global committee of parliamentarians on population and development—about 300 members of parliaments all over the world who are concerned about this same concern of yours, about the population explosion and its implications to societies all over the world.

I want to congratulate you and my colleague, Bob Garcia from New York, for your imagination, thoughtfulness and high intelligence in putting this hearing together.

Of course we know that when we delve into this area of adolescent pregnancy, of children bearing children, we're getting into a very complex and emotionally charged area, and it's particularly emotionally charged and complex here in the United States, where, alone, of all the developed countries on Earth, teenage pregnancy is on the rise.

The rate of teenage pregnancy in our country—about 95 births per 1,000 females between 15 and 19—far exceeds the rate in any other of the industrialized, developed countries.

For example, in Sweden it's 35; in the Netherlands, it's 14; in France, it's 43; in Canada, it's 44; whereas we are almost 2½ times this rate—96.

The interesting thing is that—according to the report of the Alan Guttmacher Institute—the level of sexual activity in all of these countries is approximately the same.

Now, in a developed country, when a young girl—13, 14, or 15—becomes pregnant, it has devastating implications for her life and her health. Young teenage girls are placed in a life-threatening situation.

The rate of maternal mortality and infant mortality is far higher for these early teenage pregnancies, but the results are pitiful even when that doesn't happen.

An early teenage pregnancy has blighting effects, Mr. Chairman, on a young girl's education prospects:—she almost never finishes school;—on her job prospects:—she doesn't have job skills and she isn't likely get them; and on her marital prospects. So it is a life-destroying venture that these young girls don't understand.

One last point is that when a young child has a child, there's a substantial statistical likelihood that that infant, if it's a girl, will also be a child mother and a significant statistical likelihood that that infant, if it's a boy, by the time the boy is 12, 14, 15 years old, he'll be bumping his head up against the criminal justice system.

There are two answers, and I'm sure we'll be discussing both of them today. First, young people should postpone sexual activity until it's appropriate for them in their lives; and, second, if that's not possible and not likely, then they should be able to exercise responsibility, and that means the effective use of contraception.

As I mentioned before, all of the studies show that sexual activity among young teenagers is different than it was in our generation 20, 30, or 40 years ago. Young people are becoming sexually active at a much earlier age and at more or less the same ages all over the world.

So, therefore, it behooves us to encourage sexual responsibility. That means we must give young people access to family life education, sex education, counseling, and the availability of family planning services. It's worked well all over the world, and that's what the results mean that I just suggested, where Sweden, and France, and Canada, and England, and the Netherlands have rates of adolescent pregnancy that are way less than half of ours.

Now, Mr. Chairman, success in reducing the teenage pregnancy rate in the United States will require a great deal of effort and a great deal of knowledge and compassion on the part of legislators, on the part of policymakers, and on the part of our institutions.

We had a briefing here in Congress last week that our caucus arranged which presented the attitudes of members of the various religious groups and—how they felt about family planning, sex education, and premarital sex.

The interesting thing is that among all religious groups, the people are way ahead of their institutional leaders. That's in the Orthodox Jewish Church, in the conservative Protestant sects, and in the Catholic Church as well.

As a matter of fact, we were astonished to find professional polsters telling us that Catholics were slightly more liberal than Protestants in approving, for example, premarital sex. They didn't approve of premarital sex, but they didn't disapprove of it harshly under all circumstances. There was a more forgiving, more compassionate attitude among Catholics than among Protestants.

Eighty-five to ninety percent of Catholics and Protestants in the field, when polled, approved of giving young girls and boys family planning information.

Now, that is a reality that the policymakers and the legislators have not absorbed yet, and too frequently we are intimidated, and too frequently there are disincentives for us to act because of what we perceive institutional attitudes to be among the religious group rather than finding out what the people feel.

So I want to congratulate you again for holding this hearing. It's terribly important to bring knowledge of this very anxiety-ridden, emotionally laden subject to the people, and I wish to give you the credit to which you're entitled.

Mr. WAXMAN. Thank you very much, Mr. Scheuer.

Mr. GARCIA. Mr. Chairman, if I may.

Mr. WAXMAN. Mr. Garcia?

Mr. GARCIA. I'd like to just have the opening statement entered into the record of my colleague, the ranking minority member of the Census and Population Subcommittee, Mr. Jim Hansen of Utah.

Mr. WAXMAN. Without objection, that will be the order.

[The statement of Mr. Hansen follows:]

STATEMENT BY HON. JAMES V. HANSEN

Mr. Chairman: I would like to take this opportunity to thank you and Mr. Waxman for holding this hearing today.

Adolescent pregnancy in the United States is indeed a social problem which we must address. I feel this hearing today is a step in the right direction in helping

Congress and the American people understand the problems surrounding adolescent pregnancy.

The problem of teenage pregnancy in the United States is overwhelming. We must help in educating our youth and ourselves by closely examining the variables contributing to this problem which will help us to resolve this problem.

Mr. Chairman, I would also like to welcome our distinguished panel of expert witnesses and I look forward to hearing their views as to how we can start solving the problems of teenage pregnancy.

Mr. WAXMAN. Our first witness today is Mr. William Butz, Associate Director for Demographic Fields, Bureau of the Census, the Department of Commerce, and he will be accompanied by Martin O'Connell, who is chief of the Fertility Statistics Branch, Population Division.

Mr. Butz, I'd like to welcome you.

Let me indicate to you and to the other witnesses that will be testifying today, that we have received your prepared statements. Those prepared statements will be made part of the record in full, so we're going to ask each witness—I know you've been advised in advance—to summarize those statements in no more than 5 minutes.

We're going to have to be very strict about that 5-minute rule because of other pressures on our time today. So we will set an alarm clock. At the end of the 5 minutes, the bell will ring, and we'll have to stop and then move on. But this is the only way we can get all the witnesses in and still have a full opportunity for questions and answers.

Thank you very much.

Mr. Butz?

STATEMENT OF WILLIAM BUTZ, ASSOCIATE DIRECTOR FOR DEMOGRAPHIC FIELDS, BUREAU OF THE CENSUS, DEPARTMENT OF COMMERCE, ACCOMPANIED BY MARTIN O'CONNELL, CHIEF, FERTILITY STATISTICS BRANCH, POPULATION DIVISION

Mr. BUTZ. Thank you.

It's a pleasure for the Census Bureau to be here to try to shed some light on this important topic. The 5 minutes will be difficult, but we'll do our best.

Despite recent publicity about teenage childbearing, teenage birth rates today are significantly less than they were in the 1950s.

The fertility rate for teenage women in 1982—the yellow line in the middle on that chart—was 53 births for 1,000 women 15 to 19 years old. Twenty years earlier, the annual rate of teenage childbearing was almost twice this level. Between 1955 and 1960, about 90 out of every 1,000 women 15 to 19 years of age gave birth each year.

For the past 35 years, teenage fertility rates for black women—that's the green line at the top of the chart—have been between 2 and 2½ times greater than the rates for white women.

Between 1970 and 1982, fertility rates for black teenagers fell by one-third to slightly under 100 births per 1,000 women 15 to 19 in 1982. The rate for white teenagers in the same period decreased 22 percent to 45 births per 1,000 in 1982.

From 1973, when abortions were legalized nationwide, through 1982, there were an estimated 13 million abortions. During this period, one-third were performed on teenagers.

In 1981, almost half of the pregnancies to teens 15 to 19 years old resulted in live births, and you can see this in the gold box there at the left of the figure. Four out of ten ended in induced abortions—the gold bar in the middle—and about 13 percent ended in either miscarriages or stillbirths.

Data for 1980 indicate that 40 percent of pregnancies to white teenagers and 36 percent of pregnancies to teenagers of black and other races combined resulted in induced abortions.

Teenagers have the highest average number of visits for family planning reasons to either private physicians, clinics, or counselors. Women 15 to 19 years old in 1982 averaged 1.6 visits per year, compared with an average of one visit per year for women in the later child-bearing ages.

Two-thirds of all family planning visits made by these older women, aged 20 and older, were to private physicians, while 61 percent of the family planning visits by teenagers were either to clinics or counselors.

These statistics suggest that the structure of informational and delivery services to teenagers is quite different from that of older adults.

A large increase in the percentage of children born out of wedlock to teenagers has occurred since 1950. Thirteen percent of all teenage births in 1950 occurred out of wedlock. By 1982, this figure increased to 51 percent. That's a threefold increase in the percentage of births born out of wedlock.

The majority of births to teenagers are first births, which usually have a very significant impact on the subsequent life course of women.

Using retrospective fertility and marital history information from current population surveys—which incidentally have been primarily funded by the National Institute of Child Health and Human Development headed by Dr. Wendy Baldwin behind me here—using this information, we can distinguish three categories of births to teenagers: First, children born out of wedlock; second, children conceived premaritally but born within marriage; and, third, children both conceived and born within marriage.

This next chart shows trends in the first two categories combined. In 1980–81, children either born or conceived premaritally accounted for approximately 70 percent of all first births to women 15 to 19 years old. This is the yellow line there in the middle. This is double the percentage recorded by teenagers during the 1950's. In the 1980–81 period, 64 percent of first born children among white teenagers and 97 percent of first borns among black teenagers were conceived out of wedlock. Again, both racial groups experienced substantial increases in these figures since the early 1950's.

However, the fact that a woman has had a child born out of wedlock does not mean that she will continue to live with that child without ever getting married.

Look at this figure.

Have I skipped a chart, Martin? If I have, you can move ahead. There we are.

The orange bar at the far left shows that, on average, about 20 percent of women who had a premarital first birth under the age of 30 between 1950 and 1979 married within 1 year of the child's birth. Within 3 years, about 40 percent of these women married. This is the blue box there at the left. In fact, the teenagers who had an out-of-wedlock birth were more likely to marry shortly after the child's birth than were women in their late 20's who also had an out-of-wedlock birth.

On the other hand, teenage marriages, especially those begun with the woman having had a child born or conceived out of wedlock, experience higher separation and divorce rates than first marriages entered into at older ages.

The racial differences are sharp in the percentage already having had a child or pregnant when first married for 18- and 19-year-olds.

About one-quarter of all white and one-half of all black brides aged 18 and 19 who married in the last half of the 1970's entered their first marriage either already having given birth to a child or pregnant with their first child.

Other studies based on Census Bureau data have indicated that teenage brides begin their married lives in families with relatively low levels of income and with poor employment opportunities. They have lower levels of educational attainment, are less likely to be employed, and, if employed, are less likely to be in professional or managerial occupations than women who marry at older ages.

Women who have had their first birth as an adolescent, on the average, fail to complete 12 years of school and never catch up educationally with women who delay childbearing until beyond their teenage years.

It is not easy to say the extent to which early marriage and childbirth contribute to these undesirable educational and economic outcomes, because the causality might run in the other direction as well.

In any case, early marriage and childbearing, on the one hand, and educational and economic deficits, on the other hand, do indeed go hand in hand, on the average.

In sum, this statistical profile of teenagers developed from Census Bureau data suggests that a large proportion of America's youth who enter parenthood at early ages often do so facing considerable socioeconomic disadvantages.

I'd be delighted to try to answer any questions that you have.

[The statement of Mr. Butz follows:]

TESTIMONY

OF

THE BUREAU OF THE CENSUS

STATUS OF TEENAGE FERTILITY

The transition to motherhood constitutes one of the most significant turning points in a woman's life, marking dramatic and oftentimes irreversible changes in patterns of educational and career pursuits and opportunitites.

Despite recent publicity about teenage childbearing, we should keep in mind that teenage women today are significantly less likely to have children than were their counterparts who grew up during the baby boom years of the 1950s (table 1, figure 1). Between 1955 and 1960, 90 out of every 1,000 women 15 to 19 years of age gave birth each year. Twenty years later, the annual rate of teenage childbearing fell to about one-half this level. Since the mid-1970s, no change has occurred in the teenage birth rate, with the most recent rate for 1982 being 53 births per 1,000 women 15 to 19 years old. In general, this pattern of declining fertility through the mid-1970s and subsequent stability has characterized the fertility pattern for all women in the United States for the last 25 years.

Since the 1950s, teenage fertility rates for Black women have been between 2 and 2.5 times greater than the rates for White women. The greatest differences in fertility between the two races occurred in the early 1970s. Between 1970 and 1982 fertility rates for Black teenagers declined by one-third to slightly under 100 births per 1,000 women 15 to 19 years old. The rate for White teenagers in the same period decreased 22 percent to 45 births per 1,000 in 1982.

Teenage fertility rates in 1980 were 82 births per 1,000 Hispanic women 15 to 19 years old compared with 52 per 1,000 for Non-Hispanic women. Asian and Pacific Islander teenagers had relatively low fertility rates with only 34 births per 1,000 women 15 to 19 years old.

Historically, women in the South begin childbearing at earlier ages than women in the North, East or West. In 1980, there were 66 births per 1,000 women 15 to 19 years old in the South compared with 55, 50, and 35 births per 1,000 for women living in the West, Midwest, and Northeast respectively.

A major factor alleged to affect the level of fertility in the 1970s was the Supreme Court's decision in Roe v. Wade in 1973. Thirteen million abortions have occurred between 1973 and 1982. During this period, one-third were performed on teenagers.[1/]

In 1981, 48 percent of the pregnancies to teens 15 to 19 years old resulted in live births, 39 percent ended in induced abortions, and 13 percent ended in miscarriages or stillbirths (table 2, figure 2).[2/] Data for 1980 indicate that a slightly higher proportion of pregnancies of pregnancies to White teenagers ended in abortions (40 percent) than did pregnancies to teenage women of all other races (36 percent).

Teenagers have the highest average number of visits for family planning reasons to either private physicians, clinics or counselors. Women 15 to 19 years old in 1982 averaged 1.6 visits per year compared with an average of 1.0 visits annually for women 20 years and over.

Two-thirds of all family planning visits made by women 20 years old and over were to private physicians while 61 percent of family planning visits by teenagers were either to clinics or counselors. These data suggest that the structure of informational and delivery services to teenagers is quite different from that to older adults.[3]

Births to teenage women in terms of the percentage of children born out of wedlock is also changing. The percentage of all teenage births out of wedlock increased from 13 percent in 1950 to 51 percent in 1982 and is of concern to policy makers both on the local and federal level (table 1). Special educational, child care, and assistance programs for teenage women with children affect short run public expenditures and long run social costs.

Teenagers in the Northeast had 59 percent of their births born out wedlock, the highest percentage among women in the four major regions. Little difference, however, was found among the other regions. Forty-five percent of births to women 15 to 19 years old in both the South and the West in 1980 were born out of wedlock and 48 percent were born out of wedlock among teenagers living in the Midwest.

The majority of births to teenagers are first births, which usually have a significant impact on the subsequent life-course of women. Using retrospective fertility and marital history data from the Census Bureau's Current Population Survey, we can distinguish among three categories of such births to teenagers: children born out of wedlock; children premaritally conceived but born within marriage; and children both conceived and born within marriage.

In 1980-81, children either born or conceived premaritally accounted for approximately 70 percent of all first births to women 15 to 19 years old, double the percentage recorded by teenagers during the 1950s (table 3, figure 3). In the 1980-81 period, 64 percent of firstborn children among White teenagers and 97 percent of firstborns among Black teenagers were conceived out of wedlock. Both racial groups experienced substantial increases in these figures since the early 1950s.

Current Population Survey data also show a decreasing percentage of women, when faced with a premarital first pregnancy, who marry before their children are born. Between 1950 and 1969, about one-half of teenage women who delivered firstborn premaritally conceived pregnancies married before their children were born. By the late 1970s, only one-third of these women delivered their first child within marriage.

Sharp differences in the propensity of single teenage women to marry when faced with a premarital pregnancy are found by race. Among teenage women who had a premaritally conceived birth between 1980 and 1981, 43 percent of White women married before their child was born compared with 9 percent among Black teens (table 4, figure 4). These percentages were significantly lower than the 58 and 28 percent recorded in the 1950-54 period for White women and Black women respectively.

The fact that a woman has had a child born out of wedlock does not mean that she will continuously live with that child in an unmarried state. About 20 percent, on average, of women who had a premarital first birth under age 30 between 1950 and 1979 married within one year of the child's birth (table 5, figure 5). Within 3 years of their child's birth, about 40 percent of the women married. Teenagers who had an out-of-wedlock birth were more likely to marry shortly after the premarital birth than were women who were in their twenties.

A very high proportion of teenage women begin their marital careers either pregnant or already having had a child when they are first married. Forty-three percent of women who first married under age 18 in the latter half of the 1970s were so characterized, a percentage twice as high as that recorded during the peak of the baby boom some 20 years earlier (table 6, figure 6). Ten percent of teenage brides married in 1975-79 under the age of 18 had had their first birth before they were married and another 33 percent were pregnant with their first child at the time of their marriage.

Among 18 and 19 year olds who first married in 1975-79, 9 percent of the brides also had had a premarital birth and an additional 18 percent were pregnant at the time of their marriage. These percentages are almost double what they were in the 1950s.

Sharp differences in the percentage already having had a child or pregnant when married are found for 18 and 19 year olds by race. About one-quarter of all White and one-half of all Black brides age 18 and 19 who married in the last half of the 1970s entered their first marriage already having given birth to a child or pregnant with their first child.

An analysis of data from the Current Population Survey for newly married couples showed that teenage brides relative to adult women begin married lives in families with lower levels of income and with poorer employment opportunities. They have lower levels of educational attainment, are less likely to be employed, and when employed are less likely to be in professional or managerial occupations.[4/] Women who have had their first birth as an adolescent on the average fail to complete 12 years of school and never catch up with the educational attainment levels of women who delay childbearing until their twentieth birthday.[5/]

In sum, the statistical profile of teenagers developed from Census Bureau data strongly suggests that a large proportion of America's youth who enter parenthood at early ages often do so facing considerable socioeconomic disadvantages.

FOOTNOTES

1/ Centers for Disease Control, Abortion Surveillance 1979-1980 (May 1983); Stanley K. Henshaw, Jacqueline Darroch Forrest, and Ellen Blaine, "Abortion Services in the United States, 1981 and 1982," Familv Planning Perspectives. Vol. 16, No. 3 (May/June 1984), pp. 119-127.

2/ Stephanie J. Ventura, Selma Taffel, and William D. Mosher, "Estimates of Pregnancies and Pregnancy Rates for the United States, 1976-81," Public Health Reports. Vol 100, No. 1 (January/February 1985), pp. 31-34.

3/ Marjorie C. Horn and William D. Mosher, "Use of Services for Family Planning and Infertility: United Stated 1982," Advancedata. No. 103, DHHS Pub. No. (PHS) 85-1250 (December 1984).

4/ Martin O'Connell and Carolyn C. Rogers, "Out-of Wedlock Births, Premarital Pregnancies, and Their Effect on Family Formation and Dissolution," Family Planning Perspectives. Vol. 16, No. 4 (July/August 1984), pp. 157-162. Teenage marriages, especially those begun with the women having had a child born out of wedlock or pregnant when married, also experience separation or divorce rates 2 to 3 times higher than women who marry at older ages. James McCarthy and Jane Menken, "Marriage, Remarriage, Marital Disruption and Age at First Birth," Family Planning Perspectives, Vol. 11, No. 1 (January/February 1979). pp. 21-30).

5/ James McCarthy and Ellen S. Radish, "Education and Childbearing Among Teenagers," Family Planning Perspectives, Vol. 14, No. 3 (May/June 1982), pp. 154-155.

Table 1. Births per 1,000 Women 15 to 19 Years Old and Percent of Teenage Births Born out of Wedlock: 1950 to 1982

Year	All Races	White	Black
Births per 1,000			
1982	52.9	44.6	97.0
1980	53.0	44.7	100.0
1975	55.6	46.4	111.8
1970	68.3	57.4	147.7
1965	70.5	60.6	144.6
1960	89.1	79.4	156.1
1955	90.3	79.1	167.2*
1950	81.6	70.0	163.5*
Percent out of wedlock			
1982	50.7	36.5	86.9
1980	47.6	33.0	85.2
1975	38.2	22.9	76.9
1970	29.5	17.1	62.7
1965	20.8	11.4	49.2*
1960	14.8	7.2	42.2*
1955	14.2	6.4	40.7*
1950	13.3	6.2	35.8*

* Black and other races.

Source: National Center for Health Statistics, Vital Statistics of the United States, annual issues.

Table 2. Percent Distribution of Pregnancies to Women 15 to 19 Years Old by their Outcome: 1981 and 1976

Outcome of Pregnancy	1981	1976
Total	100.0	100.0
Live births	47.8	52.1
Induced abortions	39.3	33.8
Fetal deaths	12.9	14.1

Source: Stephanie J. Ventura, Selma Taffel, and William D. Mosher, "Estimates of Pregnancies and Pregnancy Rates for the United States, 1976-1981," Public Health Reports, Vol. 100, No. 1 (1985).

Table 3. Percent of First Births to Women 15 to 19 Years Old Premaritally Born or Conceived, by Race: 1950-54 to 1980-81

Period of first birth	All Races	White	Black
1980-81	71.6	64.4	96.5
1975-79	67.5	58.1	93.4
1970-74	66.4	57.3	91.1
1965-69	54.5	47.7	81.1
1960-64	46.0	38.3	81.1
1955-59	39.4	31.4	75.3
1950-54	30.1	22.6	64.9

Source: Martin O'Connell and Carolyn C. Rogers, "Out-of-Wedlock Births, Premarital Pregnancies, and their Effect on Family Formation and Dissolution," *Family Planning Perspectives*, Vol. 16, No. 4 (July/August 1984).

Table 4. Percent of Women 15 to 19 Years Old Marrying Before the Birth of a Premaritally Conceived Child, by Race: 1950-54 to 1980-81

(Percentages refer to firstborn children)

Period of first birth	All Races	White	Black
1980-81	32.3	42.9	8.8
1975-79	34.1	47.8	10.8
1970-74	47.0	64.7	16.9
1965-69	55.8	69.8	24.4
1960-64	51.3	64.5	23.4
1955-59	53.3	66.2	29.9
1950-54	46.5	58.4	28.2

Source: O'Connell and Rogers (1984).

Table 5. Percent of Women Marrying Within One and Three Years After a Premarital Birth, by Age: First Births Occurring 1950 to 1979

Age of woman at first birth	Percent marrying within– One year	Three years
15-17 years old	20.3	40.6
18-19 years old	23.6	43.6
20-24 years old	18.9	40.4
25-29 years old	14.0	31.8

Source: O'Connell and Rogers (1984).

Table 6. Percent Distribution of Women 15 to 19 Years Old by their Fertility Status at the Time of their First Marriage, by Race: First Marriages Occurring 1950-54 to 1975-79

Race, age, and fertility status at first marriage	Period of first marriage					
	1975 to 1979	1970 to 1974	1965 to 1969	1960 to 1964	1955 to 1959	1950 to 1954
ALL RACES						
Under 18	100.0	100.0	100.0	100.0	100.0	100.0
Premarital birth	9.9	8.1	8.6	5.5	6.4	5.3
Pregnant	32.7	28.7	24.5	21.0	15.8	13.5
All other women	57.4	63.2	66.9	73.5	77.8	81.2
18 and 19	100.0	100.0	100.0	100.0	100.0	100.0
Premarital birth	9.3	8.1	7.2	5.3	4.0	4.4
Pregnant	17.7	17.6	17.6	18.0	12.0	10.7
All other women	73.0	74.3	75.3	76.7	84.0	84.9
WHITE						
Under 18	100.0	100.0	100.0	100.0	100.0	100.0
Premarital birth	6.9	5.3	6.4	3.5	2.8	2.9
Pregnant	33.5	29.5	23.8	19.7	15.8	12.5
All other women	59.6	65.2	69.8	76.8	81.3	84.6
18 and 19	100.0	100.0	100.0	100.0	100.0	100.0
Premarital birth	7.4	5.8	4.8	3.8	2.2	3.3
Pregnant	17.9	17.0	16.4	15.8	11.3	10.5
All other women	74.7	77.2	78.8	80.5	86.5	86.2
BLACK						
Under 18	100.0	100.0	100.0	100.0	100.0	100.0
Premarital birth	(B)	32.6	26.3	20.5	28.7	19.1
Pregnant	(B)	25.1	29.9	30.5	15.7	19.8
All other women	(B)	42.3	43.9	49.0	55.6	61.1
18 and 19	100.0	100.0	100.0	100.0	100.0	100.0
Premarital birth	33.0	30.3	30.1	19.6	24.5	18.7
Pregnant	16.1	23.3	29.0	36.8	22.0	14.2
All other women	50.9	46.4	40.9	43.6	53.5	67.0

(B) Base too small to derive percent distribution.

Note: Women are classified as pregnant at marriage if they had a child 0 to 7 months after their first marriage. Women childless at their first marriage or if their first birth occurred 8 or more months after their first marriage were placed in the "All other women" category.

Source: Bureau of the Census, Current Population Reports, Series P-20, No. 385, table 8.

Figure 1. Births per 1,000 Women 15 to 19, 1950-1982

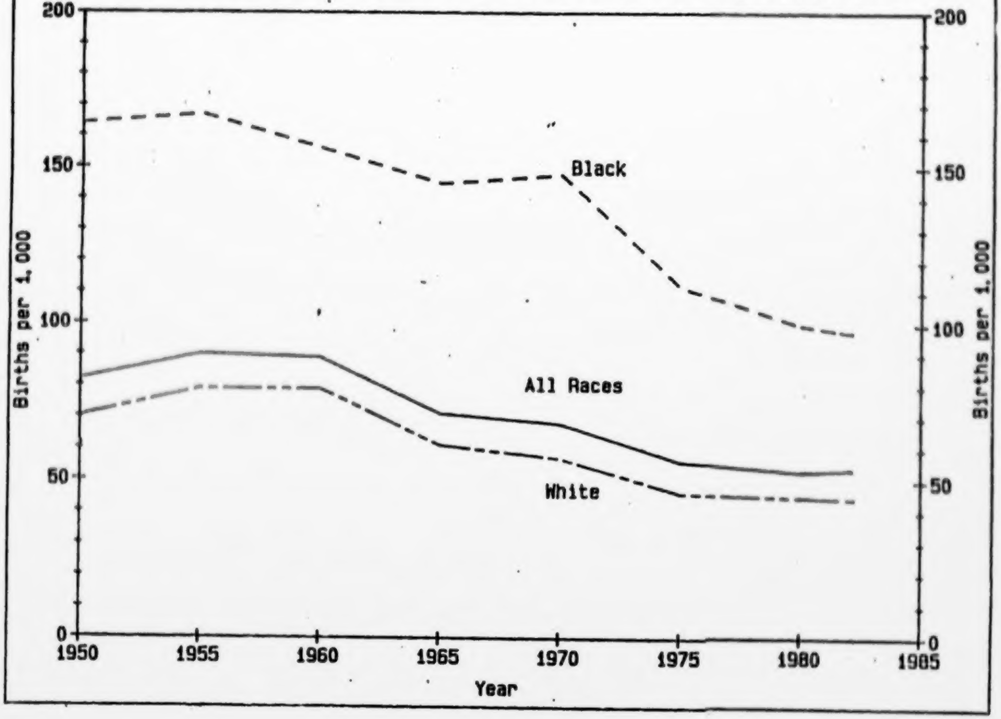


Figure 2. Percent Distribution of Pregnancies to Women 15 to 19 by Type of Outcome, 1976 and 1981

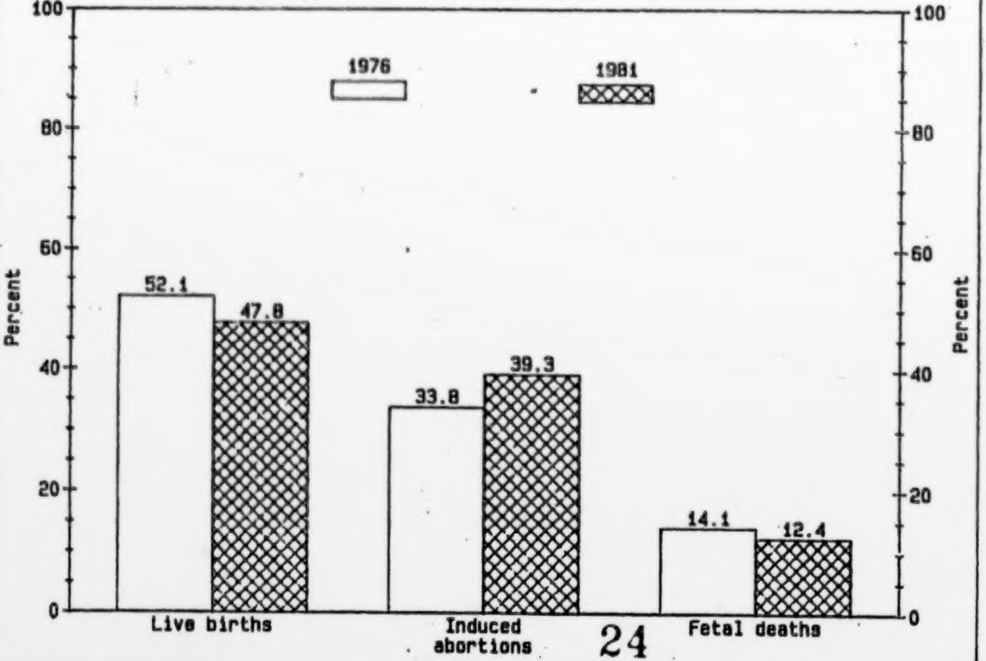


Figure 3. Percent of First Births to Women 15 to 19 Premaritally Born or Conceived, 1950-54 to 1980-81

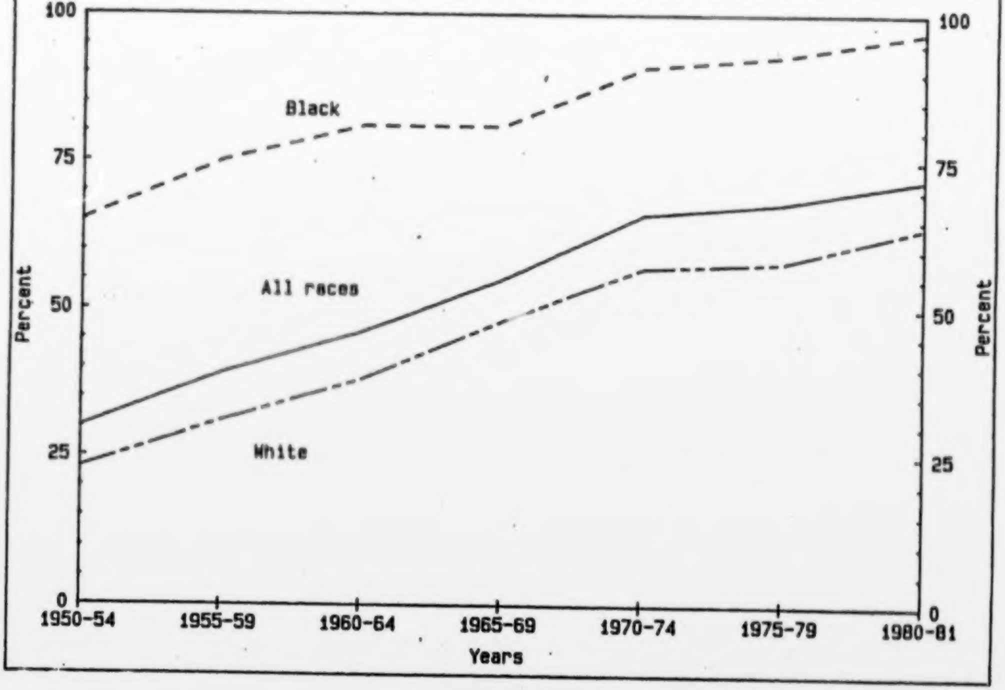


Figure 4. Percent of Women 15 to 19 Marrying Before a Premaritally Conceived First Birth, 1950-54 to 1980-81

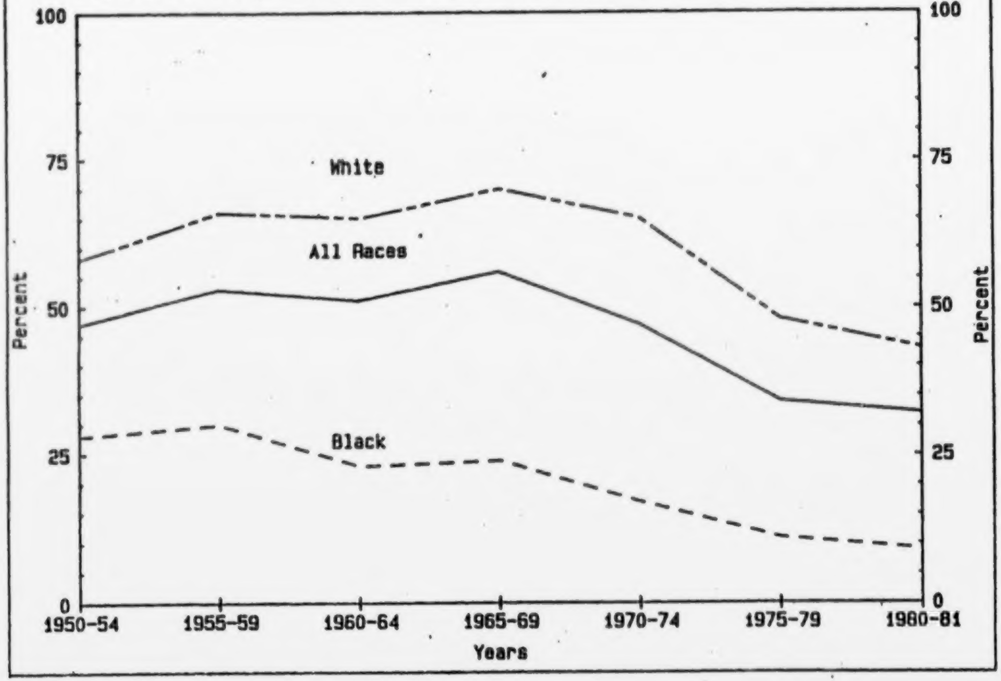
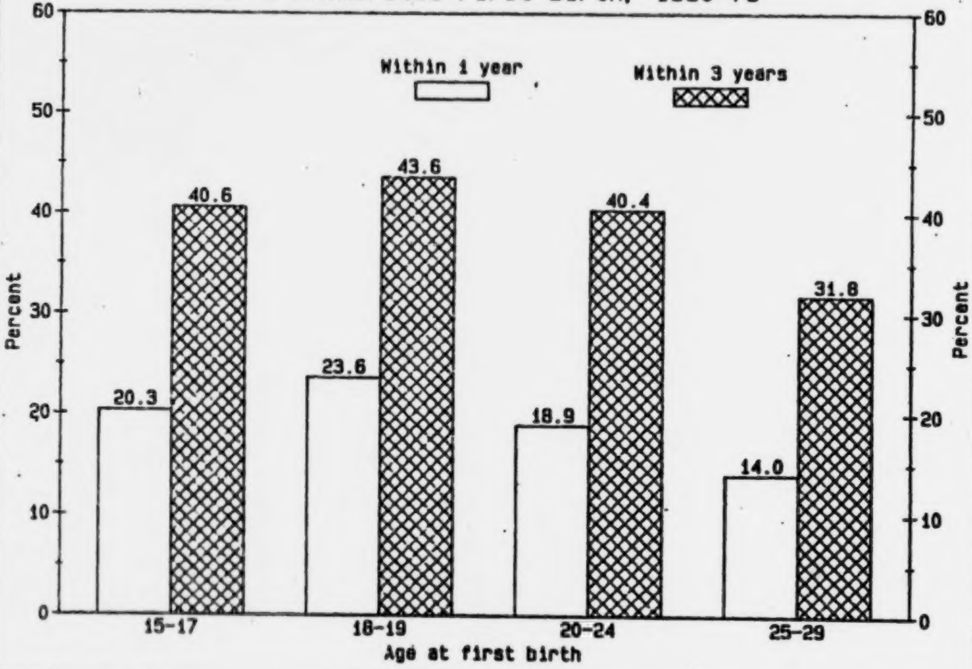


Figure 5. Percent of Women Marrying Within One and Three Years of a Premarital First Birth, 1950-79



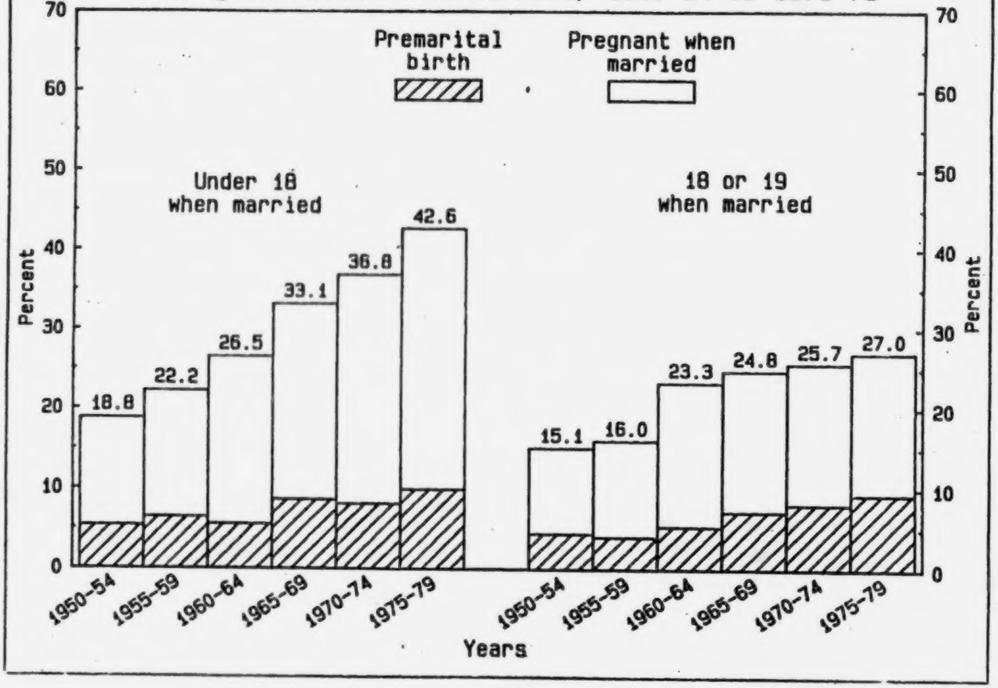


Figure 6. Percent of Teenagers with a Premarital Birth or Pregnant when First Married, 1950-54 to 1975-79

Mr. **Waxman**. Thank you very much.

Did you time this presentation in advance? [Laughter.]

In your prepared testimony, you state that the annual rate of teenage childbearing has dropped to about half the level that was recorded between the years 1955 and 1960.

You appear to attribute the significant decline to the 1973 Supreme Court decision which recognized the constitutional right to abortion.

No mention is made of the progress that has been made by teenagers in their effective use of family planning services.

Has the Federal Family Planning Program been effective in helping to reduce the number of unintended pregnancies among teenagers? Does the Census Bureau keep any data on teenagers' use of contraceptives?

Mr. **Butz**. Congressman, the Census Bureau does not keep such data. Others do, and I think there will probably be testimony later.

There has, as you indicate, been an increase in contraceptive use, but the Bureau doesn't collect such data and therefore does not do studies on that relationship.

Mr. **Waxman**. Would you say—from what you do know of the situation—that the major factor resulting in the declining number of teenage births is the availability of abortions?

Mr. **Butz**. Well, certainly there is an association, simply looking at the data. In the year of that decision and in the several years thereafter, those fertility rates did drop. But that's really all we can say: That there is a visual association there.

Mr. **Waxman**. To what extent are the high rates of teenage pregnancy and childbearing among minorities related to poverty? Does teenage pregnancy occur as frequently among poor whites as among poor blacks or poor Hispanics?

Mr. **Butz**. I believe the answer is that it does not. I may refer to Dr. O'Connell on that.

Am I correct?

Mr. **O'Connell**. Our studies that have examined both the economic effects——

Mr. **Waxman**. Could you please come up and use the mike, so we will be sure to get this on the transcript?

Mr. **O'Connell**. Our studies that have examined economic effects on out-of-wedlock childbearing do indicate that for white, black, and minority populations, generally, poverty rates and low-income levels are associated with high rates of both out-of-wedlock childbearing and childbearing in general.

Mr. **Waxman**. Does the Census data provide any information about adoption or about the likelihood of teenage mothers placing infants for adoption?

Mr. **Butz**. I'll refer that one also, if that's all right.

Mr. **O'Connell**. To date, the Census Bureau has not collected any information on adoption. Another Government survey that's taken by the National Center for Health Statistics, the National Survey of Family Growth, does collect data on adoptions.

Unfortunately, studies that have been done generally are restricted to sample surveys. What we have examined, when looking at the data, shows that there is a fairly low proportion of women who have adopted children. The data base really doesn't permit us to get a clear idea of what the propensities are by different women to adopt children.

Mr. **Waxman**. What do the Census Bureau's projections on the size and composition of the future U.S. population tell us about likely trends in adolescent pregnancy and childbearing? As the baby boom generation ages, will the problem go away, or are the rates of teenage pregnancy increasing?

Mr. **Butz**. Well, there are two aspects of that, Congressman. One is the size of the population at risk, which is the number of teenage women, and that number should fall based on the baby bust which began in the early 1960s—marked by declining fertility rates—and which lasted until the mid-1970's. So that number should fall for several years yet.

The other component is the fertility rate itself, and the Census Bureau does make projections of that rate, and let me refer that also to Dr. O'Connell.

Mr. **O'Connell**. The fertility projections that we've made through the end of the century generally indicate an overall stability in the birth rate.

One interesting aspect that we found through other studies is the definite association between continuing education and lower fertility both in terms of the delaying the first marriage and delaying the first birth.

If one was to posit that there would be a general increase in educational attainment and continuing enrollment of children through high school and college, an assumption could be made that there would be a possible decline in fertility if those trends were to continue in the educational aspects of teenagers.

Mr. **Waxman**. Thank you very much.

Mr. Garcia.

Mr. **Garcia**. Thank you.

On page 3, in the second paragraph of your written testimony, you state that special educational child care and assistance programs for teen women with children affects short-run public expenditures and long-run social costs.

Would you care to elaborate on that?

Mr. **O'Connell**. Well, the short-run costs are obvious in terms of continuing education programs for teenagers in school—to enable them to continue their education and to enable them—once they have graduated, to get the job skills that they may have been unable to get while they were raising their children in the first 1 or 2 years of the baby's life. Those are short-term effects that consist of very sharp changes in budgets that local communities are especially affected by.

The long-term effects of young childbearing concerns the woman's development both careerwise and also the economic prospects that they face for the next 15 to 20 years. Longitudinal studies not conducted by the Census Bureau but by statisticians in the University of Michigan, do effectively show that early childbearing does have long-term effects in terms of lowering eventual economic prospects, in terms of the assets accumulated, and also the current earnings potential of the woman.

Mr. **Garcia**. Thank you.

Mr. **Waxman**. Mr. Scheuer?

Mr. **Scheuer**. Thank you, Mr. Chairman.

On page 3, I think, of your testimony, Mr. Butz, you describe quite a regional differential between the percentage of births that are out of wedlock in the Northeast—I think it's 59 percent—and the percentage in the South, the Southwest, and the Midwest, which is 45 to 48 percent.

What accounts for this difference, and what special impact does that have on the Northeast, and what does this mean in terms of national legislation or, more likely, special State legislation in the Northeast States where this problem of teenage pregnancy is more intense and more severe than it is, apparently, in the rest of the country?

Mr. **Butz**. Well, Congressman, there are a variety of differentials by age, by ethnic group, by religion, by education, by country of national origin, and by region in the United States. Many of these are very difficult to understand and explain.

Mr. **Scheuer**. Could you describe some of those differences?

Mr. **Butz**. Certainly.

One thing to say is that many of these differences have attenuated over time.

If you look at differential fertility rates across groups 20 or 30 years ago, they were certainly wider than they are today. For example, the Catholic/non-Catholic rate was much different and has pretty much dissolved.

Nevertheless, there still remain differences. For example, black fertility rates tend to be higher than white. Foreign-born fertility rates, in most cases, tend to be higher than domestic.

Some of the regional differences, at least, are the result of compositional differences in these populations that live in different places, but the extent to which that's true versus specific regional differences I don't know.

Martin, do you have anything to add to that?

Mr. **O'Connell**. Yes.

In terms of looking at the proportion of births that are born out of wedlock, we should remember that two components are basically involved—the number of women who have marital births plus the number of women who have their children born out of wedlock.

In the Northeastern United States, there happens to be a fairly higher proportion of single women in the teenage years than in the Southern and Western States.

Part of the effect that you see in terms of high proportions of children born out of wedlock have to do with the Northeastern United States having high proportions of single women at risk to have their children born out-of-wedlock in the first place.

If you look at the data on a basis of only unmarried women, strangely enough, the statistics show that the out-of-wedlock birth rate for teenagers is absolutely lower in the Northeast than the southern parts of the United States.

Mr. **Scheuer**. How do you account for that?

Mr. **O'Connell**. In terms of the rates, well, in the northern part of the United States, the proportion of women who are in the labor force and continue through college and high school are higher than the other parts. Again, when you look at the first birth by a teenage woman, you have to put it in the context of her life course in terms of what she sees ahead for herself and where she has been.

You have to get a perspective of her formative teenage years in terms of the junior high school and the high school experience that she has gone through and her exposure to other teenagers that may have had a child out of wedlock, or the general educational facilities that may be available to them on a regional basis.

Mr. **Scheuer.** Thank you very much, Mr. Chairman.

Mr. **Waxman.** Mr. Butz and Dr. O'Connell, we appreciate your testimony. I think this will be very helpful for us in setting at least the demographic frame of reference for this discussion.

Mr. **Butz.** Thank you very much.

Mr. **O'Connell.** Thank you very much.

Mr. **Waxman.** Our next witness is Dr. Wendy Baldwin, chief, Demographics and Behavioral Sciences Branch, Center for Population Research, at the National Institute for Child Health and Human Development.

Dr. Baldwin, I want to welcome you to our subcommittee meeting this afternoon.

Again, your prepared statement will be in the record in full, and we'd like to ask you to summarize, if you would, in around 5 minutes.

STATEMENT OF WENDY BALDWIN, CHIEF, DEMOGRAPHICS AND BEHAVIORAL SCIENCES BRANCH, CENTER FOR POPULATION RESEARCH, NATIONAL INSTITUTE FOR CHILD HEALTH AND HUMAN DEVELOPMENT

Ms. **Baldwin.** Thank you, Mr. Waxman.

I appreciate the opportunity to testify before this joint hearing, and especially the opportunity to follow my colleagues at the Census Bureau, because they have already presented a framework. I will try to build on that with some of the research that we have sponsored.

It has already been alluded to how difficult it is to keep the different changing rates and numbers and proportions in mind, and, in terms of the trends in the 1970's, it is important to realize that, because of the aging of the baby boom population, there were approximately 46 percent more teenagers during the 1970's than in the previous decade. That meant that even though the birth rates were falling rather sharply for teens, the number of births were falling only slightly.

It is important to go beyond that very general demographic picture and look at the components of teen childbearing—for example, the age of the mother.

Even though the number of births stayed more or less stable during the 1970's, there was a shift toward more births to younger teenagers and fewer to older teenagers, and because the birth rates were falling even more sharply for older women, the proportion of births that were to teens were rising.

The other thing that has already been alluded to is the marital status of the mother. There were sharp changes in the 1970's in terms of the proportion of teenagers who were married when they bore their children. The proportion of teenage births that were to unmarried women rose to 51 percent in the most recent year.

The other trend that is very important to keep in mind in terms of looking at the patterns of reproductive behavior has been the trend in sexual activity. A number of surveys give us some indication of the proportion of teenage women who have had sexual intercourse.

In 1971, little more than a quarter of teenage women reported that they had engaged in sexual intercourse. By 1976, it had risen to 39 percent, and, by 1979, to 46 percent. This is based on metropolitan women for a technical reason, but the upward trend applies to all teens as well.

We now have data from 1982 from the National Survey of Family Growth conducted by the National Center for Health Statistics, and that shows, for the first time, that the percentage having sexual intercourse has probably stabilized. For black women, there probably is a decline in the proportion of teenage women who report that they have been sexually active.

Now, this is a very important piece of information because, without an understanding of the likelihood that a teenager is sexually active, it is hard to understand what her likelihood of pregnancy would be, or her likelihood of bearing a child.

Researchers found consistent patterns among youth who begin sexual activity at younger ages. This includes earlier physical maturation, low religiosity, low parental education, coming from a single-parent family, less academic achievement, lower educational expectations, and early involvement in non-conventional activities such as alcohol or drugs.

When you put together data on births and abortions and sexual activity, it's possible to construct measures of pregnancy rates, and the trend over time, and we have calculated this from 1974 to 1981. Today we updated this to 1982. It is our opinion that, when you take sexual activity into account, the period between 1974 and the present has probably been stable in terms of the risk of pregnancy.

That means, given the sexually active population, the risk of pregnancy has probably been stable, although, of course, the likelihood of bearing a child has clearly declined.

You have asked questions about contraceptive use, and here we do see some very definite changes.

When we compare 1976 and 1982, we find a decline in the proportion of teens who report they have never used a contraceptive, a decline from 31 percent to 15 percent.

When we look at the teens who report that they have always used a contraceptive, we find it has risen from 28 percent to 34 percent.

If we look at whether the teenage woman used a method at first intercourse, it has risen from 39 percent to 48 percent.

Again, there are complexities within this data that I would like indicate. First, it is very important to look at the rapidity with which teenagers begin to use contraception after they become sexually active, because we find the risk of pregnancy is very high in those first months after initiating sexual activity.

In fact, for young women who are under the age of 15 when they first have sex, 20 percent will become pregnant within the first 6 months.

Furthermore, the pattern of adopting a contraceptive is very important, because we find that teens tend to delay seeking out contraceptive services. Teens are at high risk of pregnancy very early on after initiating sexual activity.

I have also prepared testimony regarding the consequences of teen childbearing. Much of this is already very familiar to you.

We do know that adolescent childbearing is associated with lower educational attainment for the mother. Many of these women had lower aptitude and perhaps lower motivation as teenagers, but even when you control for background characteristics, an early birth is a detriment to educational achievement. Many of these women go back to school, but our research has found that they simply do not catch up. That is a theme we have found throughout the research on the consequences.

These are not just short-term consequences at the time of the birth. We see these consequences over time as we follow these women into later years.

For example, teens are at high risk of marital disruption. This is a risk that carries on through their life. We find even their second marriages are at higher risk of marital disruption.

We also know teens are more likely to bear more children than older women, bear them at a faster rate, and to have more children that they themselves report as unwanted.

In terms of where we have asked teens about their satisfaction with their lives, with their education, their marital prospects, and their occupation, they report lower satisfaction than the women who delayed a first birth.

We also find effects on the children. Many of the effects in terms of perinatal outcome are mediated by health services that are available to the teens. When you assure good prenatal care, the pregnancy outcome tends to be very good.

Thank you.

[The statement of Ms. Baldwin follows:]

TO BE RELEASED UPON DELIVERY ONLY

STATEMENT BY

WENDY H. BALDWIN, PH.D., CHIEF
SOCIAL DEMOGRAPHER
DEMOGRAPHIC AND BEHAVIORAL SCIENCES BRANCH
CENTER FOR POPULATION RESEARCH
NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

ON

TRENDS AND CORRELATES OF ADOLESCENT PREGNANCY AND CHILDBEARING IN THE UNITED STATES

BEFORE THE

HOUSE SUBCOMMITTEE ON CENSUS AND POPULATION
OF THE COMMITTEE ON POST OFFICE AND CIVIL SERVICE
AND THE
HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE COMMITTEE ON ENERGY AND COMMERCE

APRIL 30, 1985

Mr. Waxman, Mr. Garcia, and Members of the Subcommittees:

I appreciate this opportunity to testify before the House Subcommittee on Census and Population of the Committee on Post Office and Civil Service and the House Subcommittee on Health and the Environment of the Committee on Energy and Commerce on the demographics of adolescent pregnancy in the United States.

I am Dr. Wendy H. Baldwin, Chief of the Demographic and Behavioral Sciences Branch, Center for Population Research, National Institute of Child Health and Human Development, National Institutes of Health.

I have been asked to address the trends in adolescent pregnancies and births and to review the consequences of early childbearing. Adolescent fertility behavior has received so much attention in recent years that most have already heard much about trends and may find it strange that there can be disagreement over just what the trends have been.

To put early childbearing into perspective, it is important to understand the post World War II baby boom. This was not a temporary phenomenon--an explosion that was quickly over--but rather a rise in the birth rate that lasted into the early sixties. The aging of the baby boom babies meant that during the seventies, the number of teenagers was 43 percent higher than in the preceding decade.

The baby boom was a dramatic demographic event which will continue to influence our society for many years to come. Its implication for us is simple; it means that although the birth rates for most teens were declining in the seventies, the number of teen births rose until 1970 and declined slowly thereafter. Since birth rates and numbers of births were falling faster for older women, the proportion of births to teens actually rose. If we looked no further, we might conclude that adolescent childbearing was not a problem and that the appearance of a "problem" was an artifact of the structure of the population. However, more careful review of the components of the birth rate gives a different picture.

Age of Mother

When demographers talk about teenage childbearing, they generally refer to births to women under the age of 20. Indeed, statistics are made available for five-year age groupings, and most teen births are to women 15-19. However; this groups together women who may have completed high school and who have very good pregnancy outcomes with young women who may be in junior high school and who are high risk obstetrical patients. During the seventies, the birth rates fell fastest for the oldest teens and actually rose for the very youngest, those under age 15. These teen mothers under 15 account for a very small percentage of all births (less than one-half of one percent), but these youngsters are viewed as high risk from both a social and medical standpoint. While births to women under 15 totaled less than 7,500 in 1960, they rose to almost 13,000 in 1973 before declining to the present level of about 9,800.

Marital Status of the Mother

During the seventies, the number of babies born to unmarried teenage women rose significantly from under 100,000 in 1960 to almost 200,000 in 1970 to almost 270,000 in 1982. In fact, in 1982 over half (51 percent) of births to teens were out-of-wedlock as contrasted with 15 percent in 1960. Marriage rates fell sharply during the seventies for teenage women. The rate at which single teens bore children rose, but did not approach the rate for single women 20-24. Births to unmarried mothers are frequently associated with poorer prenatal care as well as with lower economic resources.

Trends in Sexual Activity

A significant change during the seventies was the increase in the likelihood that an unmarried adolescent girl would engage in sexual intercourse. In 1971, little more than a quarter (27.6 percent) of never-married women 15-19 reported that they had engaged in sex. By 1976, the proportions had risen to 39.2 percent, and using data from metropolitan areas, we can project that 46.0 percent of never-married teens were sexually active in 1979. These data also show that in 1971 there was no age where half of the girls were sexually active, while in 1979 half (or more) of both 18 and 19-year-olds report having engaged in sex.

It is important to have measures of the likelihood of sexual activity in order to interpret trends in pregnancies and births. Obviously, only those who are sexually active are at risk of pregnancy and since that proportion changes over time and with the age of the young women, an accurate picture of these trends requires data on sexual activity. More recent data make the issue of changing sexual activity more complex. Data from the National Survey of Family Growth--Cycle III (NSFG-III) collected in 1982 indicated that the proportion of teenaged women who had ever had sexual intercourse had declined from the rates estimated for 1979. The 1982 survey indicates that 42.8 percent of never-married women aged 15-19 have engaged in sexual activity at least once. The trend from 1979 to 1982 (metropolitan women only) implies an eight-percent decline. Preliminary comparisons with other data sources corroborate this trend. To be more specific, the rates for black teens appear to have declined a little and the rates for white teens to have stabilized.

Research has found consistent patterns among youth who begin their sexual careers at an early age. This pattern consists of early physical maturation, low religiosity, low parental education, coming from a single-parent family, less academic achievement, lower educational expectations, and early involvement in non-conventional activities such as alcohol and drug use. Research also indicates that blacks begin sexual intercourse at an earlier age than whites, and males begin earlier than females.

Trends in Pregnancies

Of course, not all pregnancies end in a live birth. Five to 20 percent are lost through miscarriage, a small proportion are lost late in pregnancy or through stillbirth, and others are lost as the result of an induced abortion. Data for abortions can be combined with data on live births to estimate rates of conception. These calculations show that between 1974 and 1981, there was an eight-percent increase in the number of conceptions. We have just seen, however, that most female teens are not sexually active and that the proportion who are has changed significantly during the past decade. Also, marriage rates have been falling for teenage women. If the birth and conception rates are adjusted to take into account the proportion of young women who are sexually active, we find that the birth rate for those "at risk" has fallen 29 percent from 1974 to 1971 and that the "pregnancy rate" has declined by almost six percent.

Contraception

Contraception is not easy to practice successfully. Contraception can be expected to be even more difficult for unmarried women, and especially for teenagers. This is because effective use of contraception is linked to the process of defining oneself as sexually active, and becoming aware of pregnancy risk and its consequences. Even so, it is surprising how little difference there is in reported use of contraception by sexually active unmarried women both over and under 20. In 1982, 20 percent of unmarried women aged 20-24 at risk of an unwanted pregnancy were not using contraceptives, compared with 30 percent of comparable teen women. There are, of course, differences in methods used. Teens are more likely than 20 to 24-year-olds to use the pill and the condom; they are less likely to use the IUD or diaphragm. Teens are unlikely to be sterilized for contraceptive purposes. Probably the most difficult and the most important issue is that of contraceptive use at first intercourse. Comparing women who were between 15 and 44 in 1982, 40 percent of those who were under 18 at first intercourse used contraception, compared with 48 percent of those who were 18 and over at first intercourse. The rapidity with which young women begin using contraception after first intercourse is very important, since the probability of becoming pregnant is very high during the first months after first intercourse, the period of least consistent use of contraception.

Contraceptive use among teenagers has improved over time. National statistics show that in 1976, 36 percent of premaritally sexually active teens reported never having used contraception, compared to only 27 percent in 1979. Data from the 1982 NSFG show that 15 percent of sexually active teenage women report never using a contraceptive. There was also an increase in the proportion who reported always having used contraception--from 28 to 34 percent over that period. The percentage of 15 to 19-year-old women who reported use at first intercourse increased over the period from 1976 to 1982--from 39 percent in 1976 to 48 percent in 1982. Once they begin to use contraception, are teens effective users? First, we may look at the methods used by the 70 percent of never-married women aged 15-19 at risk of an unintended pregnancy who report they are using a method. Fewer than one-half of one percent report sterilization--and those are reports of male sterilization and the man's age is unknown. Second, the pill is far and away the favorite method with almost two-thirds of users reporting that as their method (62.3 percent). The next most widely used methods are the condom (22 percent), the diaphragm (6.4 percent), and the IUD (1.3 percent). All other methods account for 7.8 percent.

Consequences of Adolescent Childbearing

Concern about early pregnancy and childbearing revolves around the effects on the young woman, her child, the father, and other family members involved, as well as society as a whole. I will discuss the effects on the young woman's marital and family experience, her education, occupational and economic future, and her life satisfaction. There is a strong association between younger ages at first birth and higher proportions of unwanted and out-of-wedlock births, a faster pace of subsequent childbearing, and higher completed fertility. This early involvement in family life is not, however, associated with marital stability or satisfaction. Many studies confirm higher rates of marital separation, divorce and remarriage for teenage parents. Marital dissolution rates are higher the younger the adolescent is at the time of marriage, and those who marry young are likely to express regrets later about the marriage. The risk of marital dissolution is carried on through later life, and shows up in increased risks of marital dissolution in second marriages. For the adolescent mother who is not married, studies show that she is very likely to marry soon after the birth, and that she, too, is at high risk of divorce.

Education and Occupation

Women who become mothers while adolescents exhibit reduced educational and occupational attainment, lower income, and increased welfare dependency relative to their peers. One study shows that those who became mothers while teenagers had lower academic aptitudes, grades and educational aspirations to begin with, but another study found a detrimental effect of early childbearing on education even when controls were introduced for family background and motivation. The negative effect of an early first birth on education holds even when background characteristics are controlled, and is felt by both males and females, but the effect on women is stronger and increases over time. Young mothers are more likely to express regret over their educational careers.

The effect of adolescent childbearing on education is especially important since it affects occupation and earnings. A decade after high school, women who became mothers early were more likely to be working than their classmates but in jobs of lower pay and prestige and with less job satisfaction. Several studies have shown that the effect of an early age at first birth on occupational attainment is a function of reduced education and, to a lesser extent, of increased family size. The relationship between educational attainment and economic well-being is strong, and there is consequently a significant association between early motherhood and later economic distress. Women who begin childbearing as teenagers have increased welfare dependency, and at the time of a 1975 study, half of the families receiving AFDC were families begun when the mother was a teenager. The effect of early childbearing on economic attainment continues over the years as well. Few of these women "catch up" to those who delayed family building.

Life Satisfactions

As noted above, young mothers do not appear able to catch up to their peers in terms of education, occupation or earnings; other studies show that their reaction to the timing of their births does not improve over time either. A longitudinal study found that soon after the first birth, almost half (48 percent) of the teenage mothers said they wished the child had been born later or not at all. Three years later, 78 percent said that, looking back, they would choose to have their first birth later. The wantedness of pregnancies is important not only from the perspective of a new mother's satisfaction, but in terms of infant health as well. Women who report their pregnancies as unwanted (or mistimed) are less likely to receive early prenatal care and more likely to bear a low birthweight baby. Another longitudinal study found that early childbearers were more likely to have educational and marital-related regrets. A study which looked at the mother's psychological well-being when her child was in the first grade found that young teenage mothers were more likely than older mothers to report feeling very bad at this time.

Effects on the Father

Adolescent men also feel effects of fathering a child since they may drop out of school to go to work. One study found that initially more adolescent fathers were working than their classmates, at jobs of about equal prestige, and were making more money. By 11 years out of high school, however, their classmates' investment in education had begun to pay off in higher income and more prestigious jobs. The fathers of the babies of unmarried mothers may not be as affected since they appear to play a minimal role in childrearing. One study shows that less than one-fourth were in weekly contact with the child's mother several years after the birth, and frequency of contact declined over the early years of the child's life. Maintaining social contact seems to be linked with providing economic support, rather than being a substitute for it. Many of these men had limited economic means, and none of the unwed mothers in this study received economic support from the child's father for all three years surveyed.

Consequences for the Children

A number of studies have assessed the consequences of adolescent childbearing for the children involved. Several have examined the effects of maternal age on pregnancy complications and the resulting risk to the newborn. Their findings suggest that the negative effects of maternal age on pregnancy and neonatal health found in population-based studies were largely mediated by the quality of health care received by the mother and infant rather than being a function of the mother's biological age.

Studies examining the child's later development have shown that mother's age at child's birth and social factors are related to the child's subsequent physical health and cognitive and social development. One study using measurements taken at one year of age found that children of parents with low socioeconomic status and children of unmarried mothers who live alone with their children generally show poorer physical health. In addition, children of older mothers, 25 years and over, were healthier than children of younger mothers, except in cases where teenage mothers rely upon older women (e.g., grandmothers) for child care.

The social, emotional, and intellectual development past infancy of the children of adolescents continues to be related to mother's age at birth. Two studies have found a consistent tendency for children of adolescents to have slightly lower I.Q. scores than children of older mothers when measured at several ages up to seven years, and some effects of maternal age on social and emotional development have also been found. An analysis of several large U.S. data sets has shown that young mothers are at a clear disadvantage in terms of of those socioeconomic variables that relate to I.Q. (occupation, education and income) and that these factors are largely responsible for any effect of maternal age on the I.Q. of the child.

Consequences for the Adolescent's Parents

The influence of adolescent childbearing on the parental family has been one of the least examined areas, although there is evidence that the adolescents' kin--especially their mothers--are often drawn into child care and support. A longitudinal study in an urban area has found that most of the adolescent mothers were highly dependent on the family, especially during the first several years after the birth. Approximately 70 percent were living with one or both parents at the time of the birth, and more than a third were still residing with the parents five years later. Parents most typically provide room, board, and child care. Women who resided with their families during the five years after the birth were more likely to have graduated from high school, be employed, and not be on welfare. Other analyses show that the families do not experience disadvantages in their own socioeconomic and family careers as a result of the teenagers' births. In one study, the families of pregnant adolescents report a sense of renewed happiness and cohesion following the pregnancy. However, observation of their interactions show the family's perceived "honeymoon" in the period surrounding the birth is followed by disillusionment and distress. Although the adolescent mothers and their families show various styles of coping with early parenthood, generally the adolescent is more likely to see her mother as more controlling, dissatisfied with her, and less affectionate than she did before the birth of the child.

Consequences for Society

Early childbearing also has an impact on society, for when individuals cannot realize their full educational and occupational potential, society loses their economic contributions. In addition, if early childbearers utilize public services more than other women, public expenditures on programs such as Aid to Families with Dependent Children (AFDC), Medicaid, and food stamps increase. In fact, AFDC mothers are more likely to have been teen mothers than were American women in general. Estimates of the public sector costs related to early childbearing indicate that half of expenditures went to AFDC households in which the mother was a teenager at the time she bore her first child. This total does not necessarily represent the amount that could be saved if all these mothers had postponed their first birth, since some would have required public assistance regardless of their age at first birth.

Further analyses addressed the relative impact of reducing births as opposed to mediating the effects of an early birth. For example, we measured the effect on public sector costs of no women under age 18 giving birth or of all young mothers completing high school. The results show savings for all approaches, but much greater savings when a birth is averted. As we all know, prevention is preferable to corrective care.

I would like to conclude with some thoughts about the size of this problem. In 1982, there were over one million pregnancies to women under the age of 20. The number of individuals affected is, of course, much larger since these young women have parents, siblings, husbands and boyfriends. Among girls now aged 14, it is estimated that 40 percent will experience a pregnancy before age 20 and that one-fifth will bear a child. Even more sobering than the sheer numbers is the fact that the large majority of the pregnancies are unintended by the adolescent herself.

That concludes my prepared statement. I shall be pleased at this time to answer any questions that you or other Members of the Subcommittees may have.

Mr. **Waxman**. Thank you very much.

Some people argue that making contraception available to teenagers encourages them to be sexually active. What does the research show on the relationship between contraceptive availability and sexual activity?

Ms. **Baldwin**. Well, we find that it is most typical that teens delay coming for contraceptive care until they have been sexually active for some time. We find no evidence that providing contraceptive services leads to a greater likelihood that a teen will be sexually active. I know of no evidence that would support that.

Mr. **Waxman**. Is there research on the effectiveness of sex education programs in reducing sexual activity among teenagers; in improving their use of contraception?

Ms. **Baldwin**. Most sex education programs are informational programs; they are trying to increase teens' knowledge, and they clearly do that.

In terms of other effects, I think you can ask the question two ways—do they do any harm? And the answer is no; there is no evidence that providing sex education makes teens more likely to be sexually active.

Then you can ask, do they do any good? And there is some evidence that there is a little better contraceptive practice among teens who have had sex education, but many sex education programs really are knowledge-oriented programs, not programs oriented toward behavioral change in terms of seeking out contraception.

Mr. **Waxman**. In your prepared statement, you mention the health problems of children who are born to teenage parents. You did not, however, mention infant mortality.

In other hearings, we have heard about the significant relationship between the age of the mother and the likelihood of infant mortality. Do you agree that such a relationship exists?

Ms. **Baldwin**. It is clear that there is a relationship.

One of the most interesting aspects is seen when you look at the planning status of a pregnancy. There you find that unplanned pregnancies, or unintended pregnancies, are associated with poorer patterns of prenatal care, and they are associated with a greater risk of low birth weight which, of course, is a significant risk factor for infant mortality.

Mr. **Waxman**. Thank you very much.

Mr. Garcia.

Mr. **Garcia**. Thank you, Mr. Chairman.

At the bottom of page 8 in your prepared statement, you talked about what constitutes feeling bad. What effect would this have on the child?

Ms. **Baldwin**. This funding came from a longitudinal survey which looked at a number of measures of how the mothers and the children were doing. This was one of the studies that found an effect of age at first birth on the mother's reported well-being, in this case at the time the child is 6. It also found that the children who were not adapting to school, not adapting well at age 6, were more likely to have problems as adolescents.

It appears that the teen birth has an effect both on the parent and on the child.

Mr. **Garcia**. Yes.

Let me ask you a question. Do you have any studies on the number of young women who become pregnant? Are there any polls taken, or studies, as to the number of these young women who may have become pregnant and had a conversation with their parents about sex prior to sexual activity, or had some knowledge of sex? Did they receive some sex education through the home, as compared to those who became pregnant and never knew anything about it and felt that they could only become pregnant if they wanted to become pregnant?

Ms. **Baldwin**. No. I would say that the levels of information about sex and sexuality and contraception are relatively low not only for teens, but apparently for parents, too.

We have very clear evidence on the role of the parent in general terms. Among the factors related to teens involvement in sexual activity are an intact family, and high religiosity. These are family values; these speak very directly to the environment in the home.

I would say the evidence is much skimpier in terms of the parents' direct impact on events leading to specific decisions about whether to be sexually active and whether to use a contraceptive. The research is much more scattered there.

Mr. **Garcia**. Did you give us a statistic on the dropout rate of young men or fathers who drop out of school to support their children? Did you give us a figure on it?

Ms. **Baldwin**. No. At this time, I could not give you a rate.

I can tell you that the studies that have looked at the effects on the teen fathers—those who are accepting responsibility for that birth—show that if you look at them around the time when they are still teenagers, they are more likely to be employed and they may have better earnings than their peers who are not fathers. But what is happening is that the teen father starts working earlier rather than investing in education. So if you look at the men 10 years later, you find that the young men who were not involved in an early birth have better jobs, higher incomes, and higher job satisfaction.

Mr. **Garcia**. On page 3 of your written testimony, regarding trends in sexual activities, I think you explained it, but I'd appreciate it very much if you'd go over it once more.

Ms. **Baldwin**. I will be glad to do so.

Mr. **Garcia**. During the 1970's, you have said that there are indications why sexual activity among teens increased so dramatically and then began to decline in the 1980's. Would you repeat that?

Ms. **Baldwin**. That is certainly what the data are showing. For the 1970's, we are looking at data for metropolitan women only.

Mr. **Garcia**. Was it easy to do the study because you were working in a small geographic area?

Ms. **Baldwin**. No. It is because the 1979 study was restricted to metropolitan areas only. Therefore, to do the time trends, we really have to restrict it to metropolitan areas.

Mr. **Garcia**. OK.

Ms. **Baldwin**. When we did that, we found steady increases in the proportion of women 15 to 19 who reported being sexually active.

Now, between 1976 and 1979, those rates were starting to level off for black women. They are much higher than for white women, but they were leveling off, where the white rates were still going up.

Now that we have a measure in 1982, it appears that the white rates are at least leveling off, and the black rates appear to be declining.

No one ever expected the rates to go to 100 percent. The question was, what was the asymptote of that increase. We are doing some technical work on those estimates right now to improve the precision, but I think the general conclusion is sound.

Mr. GARCIA. Dr. Baldwin, thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Scheuer?

Mr. SCHEUER. Thank you, Mr. Chairman.

Dr. Baldwin, you told us that in more or less the last decade, the percentages of teenagers not using a contraceptive fell in half, from roughly 30 percent to about 15 percent. Is that about right?

Ms. BALDWIN. Yes. The proportion of teenage women who had never used a contraceptive declined.

Mr. SCHEUER. Those who never used them, yes.

Now, to what do you attribute that decline, and can you give any of the credit to the Federal Family Planning Program which this Congress has supported and which the Members here have all personally worked long and hard for?

Ms. BALDWIN. I do not have direct measures on those particular years, but certainly it is clear that teens are more likely to use family planning clinic services than are older women.

The pill is the most popular method being used by teenagers, and this is a method that is, for the most part, obtained through clinics.

There is certainly very strong evidence that the availability of contraceptive services through clinics has been important. An analysis based on data from the mid-1970's showed that the Family Planning Program had averted an estimated 119,000 births to women ages 15 to 19 in 1975-76.

Mr. SCHEUER. Just yesterday, I had lunch in Geneva with Dr. Mahler, the head of the World Health Organization, along with several other parliamentarians representing Asian and European parliaments, and we were there to urge him to do more in the way of contraceptive research, especially for the benefit of the Third World women who need it very badly.

If I had had the chance to pick your brains before that lunch—which I regret I didn't—if I had had the chance to talk to you before speaking to our own NIH people who are encouraging contraceptive research, what characteristics would you say the new contraceptive technology ought to have for teenagers and for women in the Third World who aren't contracepting now?

What are the special demands, needs, characteristics, advantages?

Ms. BALDWIN. In many ways, teens are very much like older women. First, they want methods that are safe. I think we have some problems with the methods that are available today in terms of the perceptions of risks, as well as the perceptions of the health benefits. I see that as a significant issue.

Beyond wanting methods that are safe, teens want methods that are relatively easy to obtain, and, of course, methods that are convenient to use.

Unfortunately, when you look at the demands in terms of biomedical research, it is not always possible to get all three things in the same method. Teens, like adults, have multiple requirements in terms of contraceptive methods.

I think the strategy of making available a wide range of methods that people can choose from is probably the best. Even among teenagers, there is going to be a range of needs—teens who are in stable relationships who are comfortable using one method and teens who are not; teens who need methods that are male-controlled, and those who need methods that are female-controlled. The extent to which we can widen that range of available methods; improve the ones that we have; and improve our understanding of their health benefits and risks, we will have made a major contribution.

Mr. **Scheuer**. Thank you, Mr. Chairman.

Mr. **Waxman**. Thank you, Mr. Scheuer.

Dr. Baldwin, we very much appreciate your testimony today.

Ms. **Baldwin**. Thank you.

[Ms. Baldwin furnished the subcommittee three articles which were retained in the official file. The articles were entitled, "The Children of Teenage Parents," Family Planning Perspectives; "Trends in Adolescent Contraception, Pregnancy, and Childbearing," Premature Adolescent Pregnancy and Parenthood; and a paper, "Adolescent Pregnancy and Childbearing—Rates, Trends and Research Findings From the CPR, NICHD."]

Mr. **Waxman**. Our next witness is Dr. Jacqueline Darroch Forrest, director of research for the Alan Guttmacher Institute.

Dr. Forrest, we're pleased to have you with us today. We're looking forward to hearing from you.

Unfortunately, I'm going to have to leave to go to another meeting, but my colleagues will be here. I'll look forward to reviewing some of the transcript on the issues that you and succeeding witnesses will bring up.

STATEMENT OF JACQUELINE DARROCH FORREST, DIRECTOR OF RESEARCH, THE ALAN GUTTMACHER INSTITUTE, NEW YORK, NY

Ms. **Forrest**. Thank you, Chairman Garcia, as well as Mr. Scheuer, for being here to hear about the recent study that we did at the Alan Guttmacher Institute on teenager pregnancy and fertility in developed countries.

Before talking about the findings of the study, I want to acknowledge the close cooperation of researchers at Princeton University's Office of Population Research in this study as well as the generous financial support of the Ford Foundation.

We did this study to try to find out why teenage fertility and abortion rates are so much higher in the United States than in other developed countries and to see if we could learn anything about the experience of similar countries that have lower adolescent pregnancy rates that might be used to help us reduce unintended teenage pregnancy and childbearing in the United States.

The study had two phases, and I will not go into the details of them, but the first phase looked at data from 37 developed countries and, first of all, documented what we've seen from earlier research that the United States does have a higher teenage birth rate than other countries that are comparably modernized and considerably higher than even in a number of less developed countries.

The fertility among young U.S. teens—those under 18—is particularly high.

The United States stands out on a couple of key factors in this study. In general, lower teen birth rates are found in countries with higher levels of economic development, and we would then expect that the United States would have a low, not a high, teenage birthrate.

We did find, however, two factors where the United States fit into the general pattern of other countries that have high teenage birthrates.

One was less degree of openness about sexual matters in countries with high teenage birthrates, and we have less openness about sex when compared to most other countries, and also less equitable distribution of income in the United States than most other countries that have lower teenage birthrates.

We looked in detail at five countries in case studies, looking in depth both at teenage birthrates but also teenage pregnancy rates, which include abortion as well as births of course. These countries were Canada, England and Wales, France, The Netherlands, and Sweden.

We picked these because they have much lower rates of adolescent pregnancy than the United States, they have fairly similar degrees of sexual activity, they're similar in general cultural and economic background, and we had data on abortion and on sexual activity among adolescents that would allow us to look at these factors.

We found, as you so well summarized, Mr. Scheuer, that, compared to these other countries, the United States has a pregnancy rate—now, births plus abortions—a pregnancy rate about twice as high as Canada, France, or England and Wales, about three times as high as that in Sweden, and seven times that of The Netherlands.

We found bigger differences between the pregnancy rates of the youngest teenagers. The United States was relatively higher than these other countries for the younger teenagers than all teenagers in general.

It's also noteworthy that the United States is the only one of these countries where the incidence of teenager pregnancy has been increasing in recent years.

So then we asked ourselves, why is there such a difference between the United States and these other countries that, on the face of it, should have similar rates of pregnancy?

We were looking for what reasons there might be to explain the high rates of pregnancy in the United States compared to these other countries.

We looked at the question of, perhaps young women in the United States were more likely to be choosing to become pregnant, and we found that three-quarters of those pregnant teens in the United States said they did not want to get pregnant.

If we looked just at the rate of unintended pregnancy in the United States, it ranges from 1½ to 5 times the total pregnancy rates in these other countries.

So we really cannot say that our rate is so high because our teenagers really want to be pregnant much more than girls in these other countries.

We also found that we could not explain the differences in terms of differences in sexual experience. There are some differences in sexual activity among teenagers in these other six countries, but they are not so great as differences in the pregnancy rates.

The median age at first intercourse is very similar for the United States, for France, Great Britain, and The Netherlands—a little less than 18. It's about a year younger in Sweden and about a year later in Canada, but it does not explain the differences in the pregnancy rates.

We did find that the United States has the lowest level of contraceptive use among our teenagers who are sexually active compared to these other countries, and, in particular, we found that those who were using contraception in the United States were less likely to be using the pill, even though it's the most popular method among U.S. teens; they were still less likely to be using the pill than comparable teens in the other countries; and, as has already been stated, the pill is the most effective reversable method for these teenagers to be using.

We did find that there were differences in the attitudes about use of the pill in the medical establishments of these countries—that in the other countries, there seemed to be much less ambivalence and much more of a feeling that the pill is the most appropriate method for adolescents.

Also, contraception in general and the pill in particular tend to be more accessible to teenagers in these other countries, more accessible through the medical system in general, be it through doctors or through clinics. Nonprescription methods are more widely available, especially in England and Wales, and The Netherlands, and Sweden.

Confidentiality is an important issue in every country that we looked at, but in all these other countries teenagers are much more able to obtain contraception without parental consent than in the United States, and, in fact, in some of them the government requires that even private physicians must keep the visit of a teenager to a doctor confidential if the teenager requests it.

Contraception is generally available free or at low cost in these other countries.

Would you like me to continue, or do you have time——

Mr. **Garcia**. I don't think you have that much to go, do you?

Ms. **Forrest**. Well, let me sum up with some key points that we found have been myths about teenage pregnancy that I think this study helps overturn and gives us then some new avenues that we can be looking at.

We did find that teenage birthrates and teenage pregnancy rates in other countries are lower where there is greater availability of contraception and when there is more availability of messages about sex, about responsibility in terms of sex education either in the schools or the general media.

We found that abortion is not the reason for the higher birthrates in the United States. In fact, teenagers in these other countries have lower abortion rates than our teenagers in the United States.

Also, we found that, although black teenagers in the United States and Hispanic teenagers in the United States have higher birthrates and probably even for the Hispanics higher pregnancy rates than Anglo teenagers, this does not explain the difference in our rates compared to these other countries.

When we look either at the white rates alone or the white population minus the Hispanic population—just the Anglos—we still have much higher rates of pregnancy than these other countries.

What we did find was that there tends to be a much higher degree of consensus about what the Government should be doing and the role of the government in these other countries of having responsibility to help teenagers who are sexually active avoid pregnancy and childbearing through providing services for them.

These countries have not attempted to eradicate sexual activity among their teenagers but, rather, have left that to the purview of the families, of the churches, and have focused on delivering tangible services to these teenagers to help them.

Mr. GARCIA. Dr. Forrest, thank you very much.

Ms. FORREST. Yes.

[The statement of Ms. Forrest follows the article "Teenage Pregnancy in Development Countries: Determinants and Policy Implications," from Family Planning Perspectives, which Ms. Forrest submitted as support data was retained in the official file.]

JACQUELINE DARROCH FORREST, PH.D.,
DIRECTOR OF RESEARCH,
THE ALAN GUTTMACHER INSTITUTE,

Chairman Garcia, Chairman Waxman and Members of both Subcommittees:

I am Jacqueline Darroch Forrest, Director of Research at The Alan Guttmacher Institute. I am honored to be invited to appear here today to discuss our recent study on teenage pregnancy and fertility in developed nations. Before reporting on the findings of our study, however, I want to acknowledge the close cooperation of researchers at Princeton University's Office of Population Research in every phase of the 18-month project as well as the generous financial support of the Ford Foundation.

The purpose of our study was to consider why teenage fertility and abortion rates are so much higher in the U.S. than in other developed countries; and to see if anything can be learned from the experience of similar countries which have lower adolescent pregnancy rates that might help reduce unintended teenage pregnancy and childbearing in the U.S. The study involved two phases. Phase I entailed a study of developed countries--those with per capita incomes over $2,000 per year, with a total fertility rate of less than 3.5 children per woman and with a population of at least one million. The 37 countries are listed in the study report that has been submitted to you. For these countries, we compared various demographic, social and economic factors that might be related to adolescent pregnancy and childbearing. Since only 13 countries had information on adolescent abortion rates, the analyis in this part of the study focused on teen fertility (i.e. the birthrate). We did, however, find close relationships in these 13 countries between levels of birthrates and pregnancy rates. This phase of the project confirmed earlier research showing that the U.S. has a teenage fertility rate much higher than those in other countries that are comparably modernized and considerably higher than those found in a number of much less developed countries such as Hong Kong and Singapore. Fertility among young U.S. teenagers--those under age 18--is particularly high, ranking lower only than Puerto Rico, Bulgaria, Cuba and Hungary.

The new findings from Phase I of our study relate to identification of factors associated with levels of adolescent fertility in developed nations. We found that,

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in general, lower teen birthrates are found in countries with a lower proportion of the labor force in agriculture; higher GNP per capita; greater openness about sex; less generous policies on maternity leaves and benefits; government policies to provide contraceptives to young, unmarried women; lower maternal mortality; a higher minimum age at marriage without parental consent; and lower mortality from liver cirrhosis (a proxy for alcoholism). Lower birthrates among younger teens (those under age 18) are also found where higher proportions of household income are distributed to the poorest 20 percent of the population, a higher proportion of the population is foreign born; a higher percentage of adolescent women are taught about contraception in school; and there is a lower minimum age of consensual intercourse. Lower birthrates for teens age 18 to 19 are found as well in countries which do not have a government policy to raise fertility; have lower proportions of the labor force made up of women; and a higher proportion of the population living in large cities. Many of these factors are indicators of the level of economic development. When we controlled for the level of economic development (the percent of the labor force in agriculture), lower teen birthrates were still associated with lower levels of maternity leaves and benefits; greater openness about sex; more equitable distribution of income (a greater portion of income going to the poorest 20 percent of the population for younger teens only); a higher minimum age at marriage without parental consent; and lack of a government policy to raise fertility (the last two factors for older teens only).

The U. S., then, does not fit the pattern for high teen fertility inasmuch as it does not have a pronatalist fertility policy, high levels of maternity leaves and benefits, a low minimum age at marriage or a low level of economic development. The U.S. does fit the general pattern for high teenage birthrates in that it is less open about sexual matters than most countries with low teenage birthrates and a relatively small proportion of its income is distributed to families on the bottom rungs of the economic ladder.

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Phase II of our study entailed an in-depth analysis of adolescent pregnancy and fertility in five developed countries--Canada, England and Wales, France, the Netherlands and Sweden--as compared to the U.S. The five countries were chosen because their rates of adolescent pregnancy are considerably lower than that of the U.S.; it was believed that sexual activity among young people is not very different; the countries are similar to the U.S. in general cultural background and stage of economic development; and crucial data on abortion and sexuality among adolescents were available. In short, there might be something to learn from these countries that would be applicable to the U.S.

The U.S. teenage birthrates are much higher than those of each of the five countries at every age, by a considerable margin. The contrast is particularly striking for younger teenagers. In fact, the maximum relative difference in the birthrate between the United States and other countries occurs at ages under 15. With more than five births per 1,000 girls aged 14, the U.S. rate is around four times that of Canada, the only other country with as much as one birth per 1,000 girls of comparable age.

Teenagers from the Netherlands have the lowest birthrate at every age. The birthrates are also very low in Sweden, especially among the youngest teenagers. Canada, England and Wales, and France compose an intermediate group. Birthrates are relatively high for Canadian girls aged 14-16, and rise gradually with age. The French rates are relatively low among women up to age 18, but increase very sharply among older teenagers.

In 1981, the relative positions of the countries with respect to abortion were surprisingly close to the pattern observed for births. The United States has by far the highest rate, and the Netherlands very much the lowest, at each age. French teenage abortion rates climb steeply with age, while the Canadian curve is somewhat flatter. The rate for England and Wales rises relatively little after age 17. The chief difference between the patterns for births and abortions involves Sweden, which has abortion rates

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as high as, or higher than, those of any of the other countries except the United States.

Teenage *pregnancy* rates follow the same pattern, as one would expect, since the number of births plus abortions equals pregnancies. The U.S. rates are distinctly higher than those of the other five countries; the Dutch rates are clearly lower. The French teenage pregnancy rates appear to be low among teenagers 16 and younger, and after that age to be high. The reverse is true of Canada. In the U.S., the pregnancy rates among black teenagers are significantly higher than those among whites, but even the white teen pregnancy rate in this country is higher than the rates for teens in other countries.

Thus, the six countries represent a rather varied experience. At one extreme is the United States, which has the highest rates of teenage birth, abortion and pregnancy. At the other stands the Netherlands, with very low levels on all three measures and a pregnancy rate one-seventh that of U.S. teens. Canada, France, and England and Wales are quite similar to one another, with pregnancy rates about half of that in the U.S. Sweden is notable for its low adolescent birthrates, although its teenage abortion rates are generally higher than those reported for any country except the U.S and its pregnancy rate is about one third that of the U.S. It is noteworthy, however, that the United States is the only one of these countries where the incidence of teenage pregnancy has been increasing in recent years.

The next question we asked ourselves was: why this discrepancy between the U.S. and the other countries? Lower birthrates in other countries could result from greater use of abortion to terminate unintended pregnancies. However, the U.S. abortion rate is *higher* than elsewhere--indeed, the U.S. abortion rate is as high or higher than the overall teenage pregnancy rate in any of these countries--so the explanation for the high birthrates must lie in the determinants of teenage *pregnancy*, not in recourse

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to abortion. We speculated that more young women in this country might perhaps be choosing to become pregnant. But we found that a higher proportion of teen pregnancies in this country were unintended than in the other countries. About three quarters of teen pregnancies here and in Canada are unintended, as compared to close to two-thirds in England and Wales and France and only about half in the Netherlands. If only those U.S. teens who intended to get pregnant did so, our pregnancy rate would be 22 per 1,000 women age 15-19, compared to 96 per 1,000 today.

The variation in adolescent pregnancy rates also cannot be explained away by differences in levels of sexual experience. The differences in sexual activity among teenagers in the six countries do not appear to be nearly so great as the differences in pregnancy rates. The median age at first intercourse is very similar for the United States, France, Great Britain and the Netherlands -- something under age 18 -- and is about a year younger in Sweden, and may be about a year higher in Canada.

Data a teenage contraceptive use do indicate that the U.S. has the lowest level of contaceptive practice -- which, of course, could help account for its high pregnancy rates. In particular, use of the pill-- one of the most effective methods -- appears to be less widespread among U.S. teenagers, possibly because of ambivalent attitudes toward the pill here--in other countries the pill is generally viewed as the most appropriate method for adolescents--as well as less easy access of U.S. teens to the pill.

Contraceptive services appear to be most accessible to teenagers in England and Wales, the Netherlands and Sweden. In England and Wales and the Netherlands, those seeking care may choose to go either to a general practitioner or to one of a reasonably dense network of clinics. In Sweden, there are two parallel clinic systems, one consisting of the primary health care centers that serve every community, and the other consisting of a less complete network providing contraceptive care and related services to the school-age population.

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Canada, France and the United States also have clinic systems, but these appear to be less accessible than those found in the other countries. The Canadian clinic system is uneven, with fairly complete coverage for adolescents in Ontario and Quebec, and scattered services elsewhere. The U.S. clinic network is reasonably accessible in a strictly geographic sense. Moreover, all family planning clinics receiving federal funds are required to serve adolescents. A basic drawback of the U.S. clinic system, however, is that it was developed as a service for the poor, and is often avoided by teenagers who consider clinics places where only welfare clients go.

Condoms are widely available in England and Wales, the Netherlands and Sweden. They not only are available from family planning clinics and pharmacies, but also are sold in supermarkets and other shops and in vending machines. In France and in many parts of Canada and the United States, condoms are less freely available.

Confidentiality was found to be an important issue in every country and teenagers were found to be able to obtain contraception without parental consent in all five other countries. (In Britain, however, the government is in court defending a policy of confidentiali for teens under age 16 -- a policy diametrically opposed to that defended by the U.S. government with its now-defunct "Squeal Rule").

Contraception is also generally available free or at very low cost in the countries we studied. The potential expense of obtaining contraceptive services in the United States, however, varies considerably. Indigent teenagers from eligible families are able to get free care through Medicaid, and others do not have to pay anything because of individual clinic policy; otherwise, clinic fees are likely to be modest. On the other hand, consulting a private doctor usually entails appreciable expense, as does purchase of supplies at pharmacies

Information about sex and birth control also seems to be more widespread in the other countries that we studied. Sweden has the distinction of being the first country

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in the world to have established an official sex education curriculum in its schools. The curriculum, which is compulsory and extends to all grade levels, gives special attention to contraception and the discussion of human and sexual relationships. Perhaps most important, there is a close, carefully established link in Sweden between the schools and contraceptive clinic services for adolescents. The Swedish authorities credit the combination of sex education with the adolescent clinic program for the decline in teenage abortion rates since 1975.

In Canada, England and Wales, and the United States, school sex education is a community option, and it is essentially up to the local authorities, school principals or individual teachers to determine how much is taught and at what age. In England and Wales, however, there is a national policy favoring the inclusion of topics related to sex and family life in the curriculum, whereas there is no such national policy in Canada and the United States. French policy now mandates broad coverage of sexuality for all adolescents, although in practice, interpretation of this provision similarly devolves on local decision-makers.

The Netherlands is a case apart. Coverage of sex in the school curriculum is limited on the whole to the facts of reproduction in natural science clases. The Dutch government, nevertheless, encourages the teaching of contraception indirectly by subsidizing mobile educational teams that operate under the auspices of the private family planning association. At the same time, in recent years there has been an explosion of materials on contraception and other sex-related topics in the media, much of which is of a responsible and informative nature. Youth surveys show that knowledge of how to avoid pregnancy appears to be virtually universal.

I believe our study is a very optimistic study because, while it documents how far the U.S. still has to go in reducing the levels of unintended teenage pregnancy, it shows that it _is_ possible and suggests ways it might be approached. Some widely-held beliefs about the causes of teenage pregnancy which have taken up research, programmatic and policy

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attention are clearly refuted by the evidence from our study:

- Young teenagers are not too immature to use contraceptives effectively, as evidenced by results from the other countries we studied;
- The availability of generous welfare benefits and services does not appear to be responsible for the U.S. having higher teenage birthrates than other developed countries. In fact, in all five countries, benefits are more generous than those in the U.S.;
- Low teenage birthrates in the other countries are not achieved by greater recourse to abortion--on the contrary, all have much lower teenage abortion rates than the U.S., but they have smaller proportions of teenagers getting pregnant in the first place;
- Teenage pregnancy rates are lower in countries with greater availability of birth control and sex education;
- Teenage pregnancy in the U.S. is not primarily a black phenomenon, since white rates alone far outstrip those of the other five countries, which themselves have sizable minority populations with often disproportionately high fertility;
- High teenage pregnancy in the U.S. cannot be ascribed to teenage unemployment, since unemployment among the young is a very serious problem in all the countries studied.

In all five countries we studied in depth, government actions have demonstrated a determination to minimize the incidence of teenage pregnancy, abortion and childbearing, though each has developed its own unique approach to the problem. In the Netherlands, the country with the lowest rates of any of the five, sex education in the schools is perfunctory, but clear, complete information about contraception is widely promulgated in all the media, and mobile sex education teams operate under the auspices of the government-subsidized family planning association. In Sweden, which liberalized its abortion laws in 1975, a concerted effort was made to assure that teenage abortion rates did not rise as a result, through increased attention to sex education in all

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schools and linkages between schools and contraceptive clinic services for adolescents. more so than in the United States, the pill is accepted by the medical profession as the most appropriate method for teenagers and is widely prescribed, often without the requirement of a pelvic examination. In all case-study countries, sexually active teenagers are more likely than those in the United States to use contraception and to use the pill, the most effective method. In all but the Netherlands and Canada, there is a national policy encouraging--in the case of Sweden, requiring--sex education in the schools.

Through a number of routes, with varying emphasis on types of effort, the governments of these countries have made a concerted public effort to help sexually-active young people to avoid unintended pregnancy and childbearing. In the U.S., by contrast, there has been no well-defined expression of political will. Policy makers, particularly, appear divided over what the government's primary mission should be: the eradication or discouragement of sexual activity among young unmarried people, or the reduction of teenage pregnancy through promotion of contraceptive use. American teenagers seem to have inherited the worst of all possible worlds regarding their exposure to messages about sex: movies, music, radio and TV tell them sex is romantic, exciting, titillating; premarital sex and cohabitation are visible ways of life among the adults they see and hear about; their own parents or their parents' friends are likely to be divorced or separated but involved in sexual relationships. Yet, at the same time, young people get the message good girls should say no. Almost nothing that they see or hear about sex informs them about contraception or the importance of avoiding pregnancy. Such messages lead to an ambivalence about sex that stifles communication and exposes young people to increased risk of pregnancy, out-of-wedlock births and abortions.

There are no easy solutions to the problem of unintended teenage pregnancy and childbearing and our study, while suggesting some directions, does not point to a magic

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bullet. If I could offer one recommendation it would be that we need some concensus in the U.S. on what the legitimate role of government should be in addressing the problems of teenage pregnancy and childbearing. Are we trying to eradicate premarital sex among teenagers? To reduce the incidence of teenage childbearing? Or to reduce the levels of unintended pregnancy among teens? It is in part the ambivalence about the definition of the problem and the government's role in addressing it that makes the U.S. problem so difficult to deal with effectively. If we wanted to pattern U.S. policy on that of the developed nations we studied, the focus of public policies and programs would be to prevent unintended teenage pregnancy and childbearing. The U.S. is the only country to have an official government program to discourage teenagers from having sexual relations and it is not clear whether that program is having any success. In Europe, by contrast, the morality of early sexual activity is a matter left to families, churches and other private institutions.

Hearings such as this one can help us clarify our goals and you, Chairman Garcia and Chairman Waxman, are to be commended for holding this hearing and for taking a leadership role on this issue.

I hope the information I have presented will be helpful to your two subcommittees and stand ready to answer any questions you may have.

Thank you for the opportunity to be here today.

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Mr. **Garcia**. Just to follow up on exactly what you've just finished saying, could you make suggestions as to what you think the United States should do to formulate an effective policy regarding contraception for teens?

Should we offer free contraception to teens who wish to obtain such services?

Ms. **Forrest**. Well, I think that it's clear from this and from other work that has been done in the field that, although we may think that services are available to teenagers, there are barriers to their access, and cost is a very big barrier.

If a teenager is going to a clinic, if they are eligible for Medicaid, they can get free services. In many clinics, they can obtain free or low-cost services. Half of the teenagers, however, still rely on private physicians if they are using medical contraception.

We calculated a few years ago that their average cost for that first year of use was $172, and we're selling pills that these teenagers are having to buy for about $10 a cycle. In most of these other countries, it is free or very low cost. In France, for instance, it's less than $1.

This is one factor that the teenagers themselves have told us delays their coming into clinics, delays their use of contraceptives.

So, yes; I think this is an area; it's one part of accessibility that we need to be paying attention to.

Mr. **Garcia**. On page 4 of your written testimony, you stated that teen pregnancy has been increasing in recent years in the United States. However, according to other testimony, we have been experiencing a downward trend. There is a contradiction. Would you be able to elaborate?

Ms. **Forrest**. Yes; I think so.

One of the things that is, I'm sure, difficult for many people listening to all these data is trying to separate out some of the subtleties we are making in terms of what we're measuring.

For instance, from the Census Bureau, we're shown very important and very good data; it's able to measure births, and certainly the birthrate in the United States has been decreasing over the 1970's.

It's been decreasing because a higher proportion of teenagers have been turning to abortion, and I think one of the very important lessons we learn from these other countries is that we can decrease the abortion rate among teenagers as well, and that's something very important to do.

We were looking primarily at pregnancy rates—births plus abortions—in the early 1980's, and from 1971 until about 1981 or 1982. We have increases in the pregnancy rate over that time because they were lower in the early 1970's.

Dr. Baldwin, in talking about what looks as though pregnancy rates may be a leveling off, was talking about the latter part of the 1970's. So, some of it depends on what time points we're measuring.

But it's important to remember, I think, that for teenagers we're not only talking about concern about high levels of unintended births but high levels of pregnancies that are leading to abortions that we should help them avoid.

Mr. **Garcia**. Dr. Forrest, on page 2 of your testimony you mention that the age of consensual intercourse is lower than the concentual age in the United States. What is the average age of those countries that you studied?

Ms. **Forrest**. I don't have that at the top of my head, but I'll be glad to provide it later.

Mr. **Garcia**. Yes; I would imagine that data would be pretty difficult to gather.

Ms. **Forrest**. I'm sorry, I'm having trouble hearing you.

It varies widely in the United States, and it also varies in terms of whether it's ever enforced.

[The information follows:]

The average minimum legal age for consensual intercourse for girls in the 34 countries with data is 16.3. In the U.S., the age varies by State.

Mr. **Garcia**. My colleague from New York.

Mr. **Scheuer**. Thank you, Mr. Chairman.

We thoroughly enjoyed your testimony. It was very illuminating. I have a couple of questions.

Can you narrow your focus on what accounts for the fact that, with more or less the same level of sexual activity, there's a much lesser level of pregnancy and therefore of abortion in these other countries?

Is it what goes on in the family between parents and kids? Is it some special role that the churches play—constructive, useful role—that may be more sensitive or may be more relevant to the need of these young people for family life education? Is it family life education in the schools? Is it a more imaginative and perhaps more courageous use of radio and television to carry public service programs or maybe commercial advertising of family planning which now is verboten on almost all U.S. radio stations and television stations?

What is it? How have these European countries and Canada been more successful in carrying this message to kids of sexual responsibility than we have?

Ms. **Forrest**. Well, it's an easy question to ask, and I have to say it's yes to all those things and many more, and we found no one silver bullet, no one thing that either all these countries did in common or we could say, "Look, if only we did that, it would make a difference."

But I think that what really seems to distinguish these countries from the United States has to do with a level of consensus about how people should be behaving and the fact that teenagers are expected by their peers, they're expected by their families, they're expected by the society to behave responsibly; that the message has not come from these governments that behaving responsibly is only to avoid sexuality.

It's recognized that teenagers are sexually active, that not all of them are going to be, but many of them are going to make that choice, and the governments have taken a prime role in providing the services to them, which, in many ways, is merging with the consensus they have in their countries that it is stupid to have sex without using contraception, and that, rather than either try to avoid the fact that teenagers are sexually active, or to lecture them and keep telling them not to be, and ignore the fact that they are, what these countries have done is recognize that many of them are sexually active, and they are going to provide the services for these teenagers that they need to keep from getting pregnant. And it works; they're not getting pregnant to the levels we are in the United States.

Mr. **Scheuer**. Is there any evidence that some of their success is because special attention is being directed at getting this message to young men and that they're being sexually responsible with their partners?

Ms. **Forrest**. Yes; and one of the, I think, really hopeful experiences has been that of Sweden where, in 1975, they made even more liberal their abortion law and were very concerned that they might see then an increase in the abortions among teenagers.

They did two things as part of that abortion law. One was to link clinic services much more closely with schools. They don't have them in the schools but take classes from the school, with both the boys and the girls, to clinics, so that they can see what the environment is—this is a place that will help them, that it's accessible to them.

They worked to try to make the services accessible. They also worked in their area of sex education in the schools and made some changes in it then that are applicable to both the boys and the girls, and that is, moving away from what even then tended to be more of a biology course in terms of sex education as something separate, to talking to students about their responsibilities with one another and what it meant to be in relationships with each other.

They have found that they have then had a decrease in the teen pregnancy rate; they've had a decrease in the abortion rate; they also, by the way, have shown decreases in the rate of drug use and alcoholism among teenagers.

This is directed both at the boys and at the girls, and certainly they are very conscious of it not being a one-sided situation where only the girl has responsibility.

Mr. **Scheuer**. Thank you very much.

Mr. **Garcia**. Thank you very much, Dr. Forrest.

The next panel is Martha R. Burt, director, Social Services Research Program, Urban Institute; and Ronald D. Soloway, executive director, Center for Public Advocacy Research.

I'd like to welcome each of you. I would hope that you would be able to summarize your statements in 5 minutes, so that we can get on with some questions. Your statement will be entered into the record.

STATEMENTS OF MARTHA R. BURT, DIRECTOR, SOCIAL SERVICES RESEARCH PROGRAM, URBAN INSTITUTE; AND RONALD D. SOLOWAY, EXECUTIVE DIRECTOR, CENTER FOR PUBLIC ADVOCACY RESEARCH

Ms. **Burt**. I'm Martha Burt, and I'm director of the Social Services Research Program at the Urban Institute.

I've been asked to talk about what works in the area of teenage pregnancy and parenting.

Identifying what works in the field of adolescent pregnancy and parenting is no easy task, since public policy has simultaneously addressed several goals for teenagers' sexual activity and its consequences.

In addition, it's important to recognize the larger context in which teenagers have babies.

Policy has tended to focus on the narrowest aspects of adolescent fertility but has done considerably less to face the larger framework of distressed family life, school failure, racism, and sexism that structures opportunity and choice for many teenagers who become mothers.

Once a teenager becomes pregnant, there are no good options. A book that I coauthored, "Private Crisis, Public Cost," lays out the negative consequences of teenage childbearing, and Dr. Baldwin's testimony summarizes many of them as well.

Our conclusion is that from every perspective, including the personal cost to teenagers, the health and future life chances, risks for their babies, and the public outlay for welfare, medical care, nutrition, and child protection, public policy should place its main emphasis on preventing pregnancies to teenagers.

Programs that support teen mothers and help them overcome the difficulties of early parenthood are also important, since many teens will continue to have children.

However, these care programs should share the attention of Government policy with serious prevention efforts.

The first goal of public policy that I will talk about is reducing the number and rate of first pregnancies.

Efforts to achieve this goal have taken two forms in recent years. First is attempts to persuade teens to postpone sexual activity, and second is efforts to help teens become effective contraceptors.

There is some research evidence that suggests that teens who talk to their parents—usually their mothers—about sexual activity and contraception have lower pregnancy risk. That is, they are more likely to delay initiation of sexual activity and to use contraception better.

Therefore, some programs have tried to improve teen-parent communication, while other programs have tried other persuasive approaches to promote abstinence.

To date, no research demonstrates that any program delays when teenagers will begin sexual activity. Nor does any program, including sexuality education in public schools, stimulate earlier sexual initiation.

Easily available contraceptive services do effectively reduce the number and rate of teenage pregnancies, and we've heard ample testimony to that effect.

One thing that I would like to add to that is the importance of putting affordable, accessible, and confidential contraceptive service within teenagers' reach and that consistent follow-up of contraceptive services in the manner pursued by several school-based comprehensive health programs has proven to be very effective in reducing first and subsequent births to teenagers.

It's quite important to have a legitimate way to keep asking teenagers whether they are happy with their method or whether they want another one and finding a way to maintain your contact with them and be able to convey the message that it's important to contracept.

Most of the evidence on sexuality education as it is presented in public school—is that it does not appear to improve teenagers' contraceptive effectiveness or to diminish it.

Reducing or delaying second and subsequent births to teen mothers is an important but an illusive goal. Approximately 50 percent of girls who have a first birth in their teen years experience a second pregnancy within 2 years, often while they are still teenagers.

Whereas most teens have difficulty achieving self-sufficiency with one child, research evidence indicates that the second birth makes a life of public dependency almost inevitable.

Programs for teen mothers, therefore, have stressed the importance of delaying subsequent pregnancies, with mixed results.

The best approach to delaying subsequent pregnancies, again, seems to be regular and consistent followup of appropriate contraceptive use, regardless of whatever else the program does, and, again, the school-based comprehensive health programs that make monthly follow-up contacts appear to have the best success at delaying second pregnancies to school-age children.

We already know that we can improve the health outcomes of teenage childbearing to the mothers and to the infants with appropriate prenatal care, adequate nutrition, and attention to their health outcomes for teenagers 15 and older, and several different Federal programs address those needs.

The last issue that has been important in the public policy debate has been to try to increase the self-sufficiency and reduce the long-term welfare dependency of families begun with a teen birth.

Households in which the mother had her first child as a teenager comprise a disproportionate share of all households receiving AFDC.

Teen mothers are more likely to drop out of high school, and teens who have already dropped out are more likely to have babies.

Many programs have tried to help teen mothers stay in school or complete an alternative diploma or certificate. Some programs have tried to improve teen mothers' job readiness and job skills.

Programs focusing on these goals do have some success in helping many of their clients acquire the credentials and skills necessary to support themselves.

There has been some movement off welfare—not a lot—and into the job market, which can be demonstrated as a result of program efforts, even though participants are still teenagers.

However, although some program clients do somewhat better on these critical issues than teen mothers who have not participated in special programs—and that difference tends to be fairly small—they still lag behind teenagers who have never had a baby.

Supportive services, such as child care and transportation, can help teenagers achieve the goal of finishing school, but the teens have to be motivated to want to be in school to begin with. Just providing child care to teenagers who don't have that motivation will not get them to school or to job training.

I have not talked about males, because we have no evidence so far about programs that demonstrate how to involve males effectively in either contracepting or in parenting. I think that's a very important policy focus. They have tended to get left out, and there's just no research evidence yet about how to do it well.

In concluding, I'd like to point out that the way we think about teenage pregnancy can influence the way we think about solutions.

We tend to think about getting pregnant as an active choice, as doing something, as an intended act. Yet very few teenage pregnancies are intended.

We need to understand that not getting pregnant takes intention and determination. It is the active situation. Getting pregnant is most often passive.

To avoid pregnancy, a teenager has to understand the risks, know how to avoid them, and have some reason to take the trouble to prevent pregnancy.

Too many of our teenagers cannot see a good reason to delay childbearing. Their present environment contains few models for self-sufficiency, and their future holds little hope of achievement. Motherhood is often the only adult role they can reach with ease. To change teenagers' childbearing behavior, we will have to change the context of their lives.

Thank you.

[The statement of Ms. Burt follows. A paper submitted by Ms. Burt entitled, "Exploring Possible Demonstration Projects Aimed at Affecting the Welfare Dependency of Families Initially Created By A Birth To A Teenager," is retained in the official hearing file.]

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TESTIMONY SUBMITTED TO
THE SUBCOMMITTEE ON CENSUS AND POPULATION,
COMMITTEE ON THE POST OFFICE AND CIVIL SERVICE,
MR. ROBERT GARCIA, CHAIRMAN

AND

THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
COMMITTEE ON ENERGY AND COMMERCE,
MR. HENRY A. WAXMAN, CHAIRMAN

APRIL 30, 1985

LOOKING AT PROGRAMS THAT WORK IN THE FIELD OF ADOLESCENT PREGNANCY AND PARENTING

Martha R. Burt, Ph.D.
Director, Social Services Research Program
The Urban Institute

Identifying "what works" in the field of adolescent pregnancy and parenting is no easy task, since public policy has simultaneously addressed several goals for teenagers' sexual activity and its consequences. In addition, it is important to recognize the larger context in which teenagers have babies. Policy has tended to focus on the narrowest aspects of adolescent fertility, but has done considerably less to face the larger framework of distressed family life, school failure, racism and sexism that structures opportunity and choice for many teenagers who become mothers.

Once a teenager becomes pregnant, *there are no good options*. A book I co-authored, *Private Crisis, Public Cost*,[1] lays out the negative consequences of teenage childbearing and the difficulties involved in choosing how to resolve an unwanted pregnancy. Our conclusion was that from every perspective,

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[1] Moore, Kristin A. and Burt, Martha R. *Private Crisis, Public Cost: Policy Perspectives on Teenage Childbearing*. (Washington, D.C., The Urban Institute Press, 1982).

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including the personal cost to teenagers, the health and future life chances risks for their babies, and the public outlay for welfare, medical care, nutrition and child protection, public policy should place its main emphasis on preventing pregnancies to teenagers. Programs that support teen mothers and help them overcome the difficulties of early parenthood are also important, since many teens will continue to have children. However, these care programs should share the attention of government policy with serious prevention efforts.

Reducing the number and rate of first pregnancies to teenagers is, and should remain, a top policy priority. Efforts to achieve this goal have taken two forms: attempts to persuade teens to postpone sexual activity, and efforts to help teens become effective contraceptors.

Some research evidence suggests that teens who talk to their parents (usually their mothers) about sexual activity and contraception have lower pregnancy risk--they are more likely to delay initiation of sexual activity and to use contraception more effectively once they start. Therefore some programs have tried to improve teen-parent communication, while other programs have tried other persuasive approaches to promote abstinence. To date, no research demonstrates that any program delays when teenagers will begin sexual activity, nor does any program, including sexuality education in public schools, stimulate earlier sexual initiation.

Easily available contraceptive services do effectively reduce the number and rate of teenage pregnancies. Federally funded family planning programs have contributed greatly to teenagers' ability to contracept effectively, by putting affordable, accessible and confidential contraceptive services within their reach. Consistent follow-up, in the manner pursued by several school-based comprehensive health programs, has proven very effective in reducing first and subsequent births to teenagers. On the other hand, sexuality education as it is usually taught in public schools does not appear to improve teenagers' contraceptive effectiveness.

Reducing or delaying second and subsequent births to teen mothers is an important but elusive goal. Approximately 50 percent of girls who have a first birth in their teen years experience a second pregnancy within two years--often while they are still teenagers. Whereas most teens have difficulty achieving self-sufficiency with one child, research evidence indicates that this second birth makes a life of public dependency almost inevitable. Programs for teen mothers therefore have stressed the importance of delaying subsequent pregnancies, with mixed results. Regular and consistent follow-up of appropriate contraceptive use seems to be the key ingredient to achieve this goal, regardless of a program's other objectives and activities. School-based comprehensive health programs that make monthly follow-up contacts appear to have the best success at delaying second pregnancies to school-age mothers.

Improving the health outcomes of teenage childbearing for both teen mothers and their infants was an early policy focus. Research has now demonstrated the ability of adequate nutrition and prenatal care to reduce the incidence of miscarriages, low birth weight and other pregnancy complications for teenagers 15 and older. Federal programs such as WIC (supplemental nutrition and nutrition education for Women, Infants and Children), Maternal and Child Health (now part of a block grant), and the health service aspects of federal adolescent pregnancy programs have contributed to improved pregnancy outcomes for teenagers fortunate enough to have received assistance from them.

Improving the self-sufficiency and reducing the long-term welfare dependency of families begun with a teen birth. Households in which the mother had her first child as a teenager comprise a disproportionate share of all households receiving welfare (AFDC-Aid to Families with Dependent Children). Teen mothers are more likely to drop out of high school, and teens who have already dropped out are more likely to have babies. Many programs have tried to help teen mothers stay in school or complete an alternative diploma or certificate. Some programs have tried to improve teen mothers' job readiness and job skills. Programs focusing on these goals do have some success in helping many of their clients acquire the credentials and skills necessary to support themselves. Some movement off of welfare and into the job market can be documented as a result of program efforts, even though participants are still teenagers. However, although some program clients do somewhat better on these critical issues than teen mothers who have not participated in special programs, they still lag behind teenagers who never had a baby.

Supportive services such as child care and transportation can help teenagers achieve the goals of finishing school, participating in job training, or working. If a teenager is already motivated to continue her education or participate in the job market, providing child care and helping her transport herself and her infant to the appropriate place can facilitate her efforts. However, the mere availability of child care does not appear to motivate teenagers who otherwise do not care about school to return and finish their education. Child care is important, but not the whole answer.

In concluding, I would like to point out that the way we think about teenage pregnancy can influence the way we think about solutions. We tend to think about getting pregnant as "doing something," as an intended act. Yet all but a very few teenage pregnancies are unintended. We need to understand that *not* getting pregnant takes intention and determination--it is the *active* situation. Getting pregnant is most often passive. To avoid pregnancy, a teenager has to understand the risks, know how to avoid them, and have some reason to take the trouble to prevent pregnancy. Too many of our teenagers cannot see a good reason to delay childbearing. Their present environment contains few models for self-sufficiency, and their future holds little hope of achievement. Motherhood is often the only adult role they can reach with ease. To change teenagers' childbearing behavior, we will have to change the context of their lives.

Mr. **Garcia**. Dr. Burt, thank you.
Mr. Soloway.

STATEMENT OF RONALD D. SOLOWAY

Mr. **Soloway**. I've been asked to address the policy and program implications of the data provided by the preceding witnesses.

If our objective is to reduce teenage pregnancy, we must do two things. First, we must provide available and affordable quality reproductive health care and contraceptive services; and, second, we must provide young people with life options by strengthening the capacity of families to provide adequately for their young and improve the care and opportunities provided to young people by institutions other than the family.

I would note, interestingly, that part of the AGI study indicated that teenage pregnancy rates were lower in other countries which provided a more equitable distribution of income to the poorest 20 percent of their populations.

Therefore, public policy must reinforce the capacity of mainstream institutions—families, voluntary associations, and public agencies—to adequately nurture and guide each new generation.

These institutions must also promote sexual responsibility by providing young people the education and services they need.

As a first step then, it is essential that we strengthen the capacity of families, in whatever form they exist, to provide adequately for their young.

Our social policies and public expenditures must aim to:

One, maintain an adequate number of jobs. People unable to enter or stay in the labor market because of changes in the economy are handicapped in their roles as marital partners and family providers unless they can provide suitable work.

Two, ensure that jobs provide adequate wages. With an increasing proportion of single parents, it is imperative that a working parent be able to support a family on one income.

Three, encourage young women to prepare seriously for work outside the home, since most will have to enter the labor market at some point, and many will have to be the breadwinner for their families.

Four, support working parents, especially those who are low-income, with after-school programs and child-care subsidies, so that all parents can provide high-quality care for children while they are away with family members.

There are several more, but I'm going to skip to another part of the speech.

As a second step, we must improve the care and opportunities provided for children and teenagers by institutions other than the family.

It is essential that excellence and equity in public education be given the highest priority.

We know how to help children learn happily and successfully. Gender, race, or family income should not constrict a child's chance to acquire knowledge and pursue personal interests.

For poor children, high quality early childhood education is critical, as the findings from the Perry Preschool Project in Ypsilanti, MI, documented.

Also, our high school dropout rates are but one indication that high schools must be restructured to ensure that all youngsters can learn and grow at school.

Girls must be adequately prepared for the world of work. We must change the institutional policies and practices which maintain sex segregation and stereotypes in vocational education and employment training.

Reproductive health care for family planning, abortion, or sex-related care must be accessible and affordable to minors and young adults regardless of their marital status.

A majority of our young people begin having sex during their teenage years. They need help in learning how to make decisions about sex wisely, especially with respect to using contraception.

Schools are the ideal place to provide youngsters the education services which will ensure that they understand how to prevent pregnancy and can do so. As we heard earlier, school-based health clinics are an especially promising approach.

Pregnancy and parenting teens must be given special assistance with completing their education, training for employment, securing adequate child-care assistance, and providing appropriately for their children.

To reduce teenage pregnancy, we must pursue policies which reduce poverty and its deleterious effects and enhance access to contraception.

The following policies and public expenditures constitute, to my mind, the building blocks of a sound public commitment to prevent teenage pregnancy. I'll read some of them in each category.

Under education, a Head Start entitlement program for all three- and four-year-olds residing in families below the Federal poverty line; increased chapter I expenditures in the Education Consolidation and Improvement Act to augment educational services in low-performing poverty communities; an amendment to the Elementary and Secondary Education Act of 1965 to establish a program to promote more effective schools and excellence in education as introduced as H.R. 747 by Congressman Hawkins; financial incentives to school districts mandating family life sex education programs to students in grades 1 through 12; financial incentives to school districts, increasing teacher salaries, to attract and retain more qualified staff.

Presently, because teaching is perceived as women's work, teachers are underpaid, and therefore many qualified men and women choose other professions to the detriment of our nation's students.

Six, a school-based comprehensive service center initiative, which would enable schools to offer a range of services like health counseling and child care, which meet the special needs of students, including those at risk of pregnancy, pregnant adolescents, and teen parents.

Under health, we need a reproductive health care entitlement program for all teenagers regardless of income, including family planning, abortion, and pre- and post-natal care services.

A first step toward this goal would be a requirement that States increase their title XIX income eligibility levels for clients in need of reproductive health care.

Increased title X and title XX expenditures—which I know that Congressman Garcia is well aware of, because it's embodied in his bill—incentives to States to develop hospital-initiated case management services to all teenagers giving birth, using both Government and community resources to provide services designed to ensure the health and economic independence of young mothers; and support for the WIC program.

Under employment, a voluntary and limited national service initiative which would serve youth who want to perform a useful public service and acquire employment experience. This would require a substantial expansion of such familiar programs as the Job Corps, Vista, the Peace Corps, and the expansion of the youth component of JTPA to include public sector employment.

Just one or two more, if you please.

Under family support, we'd need to address the issue of setting a national minimum benefit for AFDC recipients, providing incentives to States to increase benefits, and require States to adjust their State need standards to fully reflect changes in living costs over the last 20 years.

Grants to States for the development of programs which encourage voluntary comprehensive education, training, and employment programs for pregnant women and mothers with children under six on AFDC.

These programs ought to include the full range of support services. I'll end there. There are a couple more, but you've got the testimony.

[The statement of Mr. Soloway follows:]

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Teen Pregnancy: A Call for Commitment, Common Sense and Compassion at the Federal Level

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April 30, 1985

Teenage pregnancy remains a major social problem in the United States. A large proportion of our young people continue to be involved with pregnancy in their teenage years and the results are sobering. Pregnant teenagers rely heavily on abortion as a means of fertility control and a significant proportion, especially in poor communities, become parents before they can manage the responsibilities they have incurred. The long-term effects of premature parenthood on both the teenagers and their children are well documented and disquieting. Public expenditures on the problems associated with teenage pregnancy and parenthood are costly.[1]

We must not continue to tolerate such high rates of teenage pregnancy, abortion, and childbearing. And we need not. Adolescent pregnancy is a far more serious problem in this country than it is in the other developed countries which are culturally and economically similar to the United States.

In a massive comparative study of teenage sexual activity and fertility in the United States and 36 other developed countries, the Alan Guttmacher Institute found rates of teenage pregnancy, abortion, and childbearing to be lowest in those countries which have the most liberal attitudes toward sex, the most easily accessible contraceptive services for teenagers, the most effective formal and informal programs for sex education, and a more equitable distribution of income to the poorest 20 percent of the population. In these countries, the governments see it as their responsibility to help teenagers avoid pregnancy.[2]

Increasingly, experts view teenage pregnancy and parenthood as symptoms of the failure of our democratic institutions, both at a political and community level, to ensure that young people's developmental needs are met.[3] This is a critical problem because both human lives and the health of our democratic process are at stake. Democracy promises and derives its strength from equality of opportunity Yet we are neglecting to provide all our young people with help to be sexually responsible, and with options to pursue meaningful roles and forego parenthood until they are able to manage the obligations involved.[4]

The consequences of our policies of neglect are most damaging for youngsters from poor families. While young people from economically secure families are more likely to delay sex until their late teens or early twenties and abort if they become pregnant, young people from poor families are more likely to engage in early sexual intercourse and bear children.

If we want to reduce the incidence of teenage pregnancy, we must ensure adequate opportunities for healthy development for all our youth. Such an approach will not only help prevent teenage pregnancy, abortion, and childbearing, but also will help prevent other problems associated with young people -- drug abuse, school failure and dropout, juvenile delinquency and crime, and teenage suicide.

Public policy must reinforce the capacity of mainstream institutions--families, voluntary associations, and public agencies--to adequately nurture and guide each new generation. These institutions must also promote sexual responsibility by providing young people the education and services they need. However, because such prevention efforts will not be adequate to the need nor perfectly executed and because people do make mistakes, we must also provide special approaches which offer help for teens who develop problems in the course of growing up--for teens who get involved in premature sexual activity, have an unwanted pregnancy, or choose parenthood before they can manage such a responsibility adequately.

As a first step, then, it is essential that we strengthen the capacity of families--in whatever form they exist--to provide adequately for their young. Our social policies and public expenditures must aim to:

- Maintain an adequate number of jobs--people unable to enter or stay in the labor market because of changes in the economy are handicapped in their roles as marital partners and family providers unless they can find suitable work.
- Ensure that jobs provide adequate wages--with an increasing proportion of single parents, it is imperative that a working parent be able to support a family on one income.
- Encourage young women to prepare seriously for work

outside the home, since most will have to enter the labor market at some point, and many will have to be the breadwinner for their families.

- Support working parents, especially those who are low-income, with after-school programs and child care subsidies so that all parents can provide high quality care for children while they are away from family members.
- Assist communities in developing family self-help centers and programs based on local need.
- Empower parents to take a more active and positive role in the education of their children in the following areas: acquiring basic academic skills, preparing for employment, learning one's ethnic heritage, developing a moral framework for action, and assuming responsibility for one's sexual behavior.

As a second step, we must improve the care and opportunities provided for chidren and teenagers by institutions other than the family. It is essential that:

- Excellence and equity in public education be given the highest priority. We know how to help children learn happily and successfully. Gender, race, or family income should not constrict a child's chance to acquire knowledge and pursue personal interests. For poor children, high quality early childhood education is critical, as the findings from the Perry

Pre-school Project in Ypsilanti, Michigan, documented.[5] Also, our high school dropout rates are but one indication that high schools must be restructured to ensure that all youngters can learn and grow at school.

- Youth serving institutions offer young people a chance to pursue positive and meaningful roles in community work, in part-time jobs, and in arts or sports activities through churches, social service agencies, youth clubs, and recreational groups.
- Girls be adequately prepared for the work of work. We must change the institutional policies and practices which maintain sex segregation and stereotypes in vocational education and employment training.[6]
- Reproductive health care for family planning, abortion, or sex-related care be accessible and affordable to minors and young adults regardless of their marital status. A majority of our young people begin having sex during their teenage years. They need help in learning how to make decisions about sex wisely, especially with respect to using contraception. Schools are the ideal place to provide youngsters the education and services which will ensure that they understand how to prevent pregnancy, and can do so. School-based health

clinics are an especially promising approach.

- o Pregnancy and parenting teens be given special assistance with completing their education, training for employment, securing adequate child care assistance, and providing appropriately for their children.[8] In practice, if not by policy, a great proportion of young mothers are not offered sufficient support to enable them to manage well as parents. So, too often teenage mothers remain out-of-school or on welfare solely because we have made it too difficult for them to do otherwise. It is imperative that we restructure our income maintenance system and offer teenage mothers on welfare small, intensive programs in which they can finish school, prepare for work, secure sound child care arrangements for their children, develop basic skills as a parent, and learn how to manage their responsibilities at work and at home.[9]

* *

To reduce teenage pregnancy we must pursue policies which reduce poverty and its deleterious effects and enhance access to contraception. Common sense, compassion and leadership at the federal level are essential. The following policies and public expenditures constitute the building blocks of a sound public commitment to prevent teenage pregnancy. Congress should consider these initiatives to prevent teenage pregnancy and assist young parents and their children:

Education

1. a Headstart entitlement program for all three and four year olds residing in families below the federal poverty line;
2. increased Chapter I expenditures (Education Consolidation and Improvement Act) to augment educational services in low-performing, poverty communities;
3. an amendment to the Elementary and Secondary Education Act of 1965 to establish a program to promote more effective schools and excellence in education -- introduced as H.R. 747 by Congressman Hawkins and known as the Effective Schools Development in Education Act of 1985;
4. financial incentives to school districts mandating family life/sex education programs to students in grades one through twelve;
5. financial incentives to school districts increasing teacher salaries to attract and retain more qualified staff (presently, because teaching is perceived as "women's work" teachers are underpaid and, therefore, many qualified men and women choose other professions to the detriment of our nation's students) and,
6. a school-based comprehensive service center initiative which would enable schools to offer a range of services like health, counseling and child care which meet the special needs of students, including those at risk of

pregnancy, pregnant adolescents, and teen parents.

Health

1. a reproductive health care entitlement program for all teenagers regardless of income including family planning, abortion and pre-and post-natal care services (a first step toward this goal would be a requirement that States increase their Title XIX income eligibility levels for clients in need of reproductive health care);
2. increased Title X and Title XX expenditures (Public Health Act) to expand family planning services as proposed in H.R. 947, the Comprehensive Adolescent Pregnancy Program Amendments of 1985 introduced by Congressman Garcia;
3. the Reproductive Health Equity Act (Representatives Green (R) and Fazio (D)) which would reinstate federal reimbursement for abortion services in the following programs: Medicaid, Indian Health, Peace Corps and Federal Health Benefits;
4. incentives to States to develop hospital-initiated case management services to all teenagers giving birth using both government and community resources to provide services designed to ensure the health and economic independence of young mothers; and,
5. support for the Women, Infant and Children program to provide supplemental food to low-income children and pregnant women at nutritional risk.

Employment

1. a voluntary and limited national service initiative which would serve youth who want to perform a useful public service and acquire employment experience -- this would require a substantial expansion of such familiar programs as the Jobs Corps, VISTA, the Peace Corps and the expansion of the youth component of JTPA to include public sector employment.
2. enactment of legislation that would permit teenage parents leaving welfare for the world of work to retain supplmentary services such as Medicaid, child care, and food stamps for two years.
3. exemption of parenting teenagers from JTPA performance standards and offer incentives for collaboration among public agencies to ensure adequate child care for enrollees.

Family Support

1. increased support for needy families on AFDC by setting a national minimum benefit, providing incentives to States to increase benefits and require States to adjust their State needs standards to fully reflect changes in living costs over the last 20 years.
2. grants to States for the development of programs which encourage voluntary comprehensive education, training and employment programs for pregnant women and mothers with children under six on AFDC (programs should include the full range of support services);
3. elimination of the time limit on work incentives for AFDC recipients with very low paying jobs;

4. a requirement that States provide AFDC to pregnant women with no other children from the point the pregnancy is medically verified, rather than allowing coverage only from the sixth month;
5. replication of effective strategies to establish paternity and enforce child support for the children of unmarried teenage mothers.

Child Care

1. provision of a Title XX setaside for high quality child care for low income working parents.

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Mr. Soloway. I would just add, I expect that the first question you might ask me is that this is an expensive list of——

Mr. Garcia. Have you had an opportunity to read the questions I'm going to ask?

Mr. Soloway. Excuse me?

Mr. Garcia. Have you had an opportunity to read the questions that we were going to put forward?

Mr. Soloway. No, I haven't.

Mr. Garcia. Well, that's exactly the first question, and I'll read it to you, if I may.

Mr. Soloway. Sure.

Mr. Garcia. Understanding the enormous costs involved in implementing the programs which you outlined in your statement, can you suggest any financing or funding alternatives other than the Federal Government?

Mr. Soloway. Well, I do think that the State and the local governments have a role in this, though I do think that with anything this major, it does have to be a Federal initiative.

I was trying to count up how many missiles and things like that it would take to fund all this, but I'm not an expert in defense expenditures.

But it seems to me that, you know, when you want to address the issue of teen pregnancy, truancy, juvenile delinquency, a lot of them have the same roots, and those roots are in poverty.

What often happens—I, as an advocate in New York State, don't have particularly a Federal perspective, but what happens is that we get $2 million here, $5 million there, and essentially—I don't know how else to say this, but we essentially get bought off on the issue thinking that we've done something, and though we've done a little bit of incremental good, in a lot of ways, what we've done is just ensured that we're helping a couple of people but ensured that we all have another generation of young people who have been destroyed that we then have to provide services to.

Unless this country has or develops a national youth development policy that addresses all these issues together with significant resources, we'll be back here for my lifetime and everybody else's lifetime, talking about the same thing.

Mr. Garcia. Well, just to follow up on that. In your opinion, how long would it take before we realize a significant downward trend in the rate of adolescent pregnancy in the United States, based upon your testimony?

Mr. Soloway. Oh, it's all conjecture. I'd like to say 30 years, because I'm 35, and by the time I'm 65, I'd like to see something happen so I can retire feeling that my life has accomplished something for my small block in this world.

It seems to me—I would say 5 or 10 years, but I don't really know. I just know that these are the approaches that need to be put in place, and it depends how quickly the money can be made to roll.

Mr. Garcia. Yes.

Mr. Soloway. Maybe somebody else would like to answer that question.

Mr. **Garcia**. Dr. Burt, recently I held of an ad hoc hearing at a high school in my district in the Bronx—Roosevelt High School on Fordham Road, just across the street from Fordham University.

I think one of the most telling points that came out of that hearing—I had a young teenage woman with me who was also a high school student and who was raising a family.

What I found most interesting was that, this young lady was able to reach the audience of maybe 400 to 500 young people of predominantly black and Hispanic population in that school.

What I found most interesting in the hearings that we've conducted is that in some instances, many of these young women, as was stated by one of the panelists, actually look forward to having the child. It was an escape it put them into the world of adulthood.

When that young lady started to talk about what it cost her for Pampers on a weekly basis, and when she said it cost between $10 and $15 a week, I immediately looked around that room, and everybody in that room, all of a sudden, understood the other side.

Do you feel that it would be well worth our while to hold hearings like this in public schools throughout the country, whether they're in predominantly minority communities, or just classic suburban communities, let's say, like Bethesda?

Dr. **Burt**. Well, it can't hurt, and I think it probably does do some good from the experience of the programs that I'm familiar with, who have tried to organize panels of their clients to go into the schools and to do exactly what you're talking about, to try to bring some of the reality home to the teenagers who do not yet have babies and who are not yet pregnant.

I think that most of the experience of programs and most of the evidence indicate that teenagers are not very good at forward planning, and they're not very knowledgeable or cognizant about the real consequences to them.

To the extent that they know much about babies, they may have babies in their families that they have taken care of for years, but they haven't paid the bills, and they haven't been theirs. They do indeed have very limited access to other respected roles in the community; and they, in many instances, especially in minority communities, perceive that there will not be a whole lot of condemnation if they do have a baby, and that they will have an adult status as a consequence of that.

I think some of the most effective one-to-one programs are putting the human consequences and the human terms in front of the teenagers who haven't thought about that yet.

There is, however, a link which I'm not sure that this approach will help a whole lot on, and that is, they have to take the information they get and then put some action to it.

The teenagers who are not yet pregnant have to say, "OK, well, if I don't want this to happen to me, then I have to become a more effective contraceptor," and I think some of those links are also not made possibly in part because teenagers aren't used to thinking ahead that much and making those connections.

I think the evidence of the international comparisons is very telling in that respect, with saying, well, teenagers in other countries can do it, and therefore there's some teaching that we have to do and some connections we have to help teenagers make in this country, which means we have to be willing to talk about the fact that they are having sex and that there are some consequences of that.

Mr. **Garcia**. Yes.

Dr. Burt, just one last point I'd like to make before I turn it over to my colleague from New York.

Another point that I found very telling in another hearing that we held also in my district in the Bronx was when I had the panel of about six young people, all of them parents, all of them teenagers, all of them from my community.

There were five young ladies and one young man, and I asked the young man, "What would you do? Let's say you are an adult; you are now 40 years old. Your child comes in and says to you, 'Dad, I'm going to have a baby.' "

I said, "What would your response be to that?" and he looked at me very sincerely, and he said, "Well, I'd take my son, and I would talk to him, and I'd try to be understanding." I said, "Wait a second. I didn't say it was your son. It's your daughter," and he said to me, "Man, you're putting me on the spot."

The point that I got out of that, very frankly, was that there's a double standard in terms of what the male's role is, as opposed to what the female's is.

It just seems to me that the question of education is not one that should be just isolated, because most of us talk just about the young lady, because she is the one who is going to carry the child and, in all likelihood, care for that child, while the young man can just go off about business on his own.

So I say that to you because, again, I go back to the question of double standards, and what can we possibly do about that?

Ms. **Burt**. A good question, and a good observation.

There's definitely a double standard out there. Very few fathers talk to either their sons or their daughters. Mothers talking to their sons seem to have some effect on reducing pregnancy risk for their sons, but the message to young men is, "Go ahead and have fun; it's not your risk," and that message is coming from all different directions, and a counter-message is not coming from parents and is not coming from other people that those boys respect.

The culture that they're in with each other is very much a culture of how to avoid getting caught with the burdens of fatherhood rather than how to not impregnate somebody, as you listen to young men talking to each other.

I think that's a critical issue. I don't have any very good answers for how to address it, but I have some ideas, including some very highly respected men in our country trying to get on that particular bandwagon.

I mean, you get Michael Jackson to make some TV spots about male responsibility, and try to take it from there in terms of other people of similar respect for teenage boys, of thinking seriously about what responsibility means, I think you may get further than a whole lot of other kinds of preaching.

Also, I think that boys don't tend to take this back to their own family. I think you asked this young man a very good question about, "What if it's your daughter, or what if it's your sister?"

They're very frequently willing to get each other's sisters pregnant and to not think about what that means in terms of the consequences or life future for their own family, and some kinds of alliances that work on taking the whole family—the teenage boy, the teenage girl, and the parent, or the mother—and working in that entire context, to say, "None of us are going anywhere unless all of us behave responsibly."

Mr. Garcia. My colleague from New York.

Mr. Scheuer. Mr. Chairman, I'm going to yield to my colleague, Mr. Leland, the chairman of the Select Committee on Hunger.

Mr. Leland. I thank the gentleman for yielding, and I'd like to thank the chairman, too, for his leadership on this matter.

I have introduced legislation addressing this issue and I have been very active in working with the problem of teenage pregnancy in Houston. In doing so, I have found some astounding facts about the treatment of potential young teenage mothers, and I guess mothers who have repeated the so-called social offense.

The Houston Independent School District pays very little attention to this problem. They have a school literally at the end of a dead-end street that's near another city called Pasadena, TX, which is another whole world unto itself, and the school district just recently allowed the students to have counselors.

Before, they didn't qualify for counselors because the formula that the school district had used—it used the average daily attendance for the students who were enrolled in the schools, and thus—these girls didn't qualify for counseling at the school, which was absolutely astounding to me. Because, if anyone needed counseling, it was these young people.

Anyway, I'm particularly concerned about the overall question of teenage pregnancy from several different points of view.

One of these is, the problem of infant mortality and how that relates to the teenage mother. The others are what happens to the teenage parents once they have delivered the child; what happens to the child once the child is born; how institutions are going to take care of these children in a comprehensive manner; how these young kids who are having children are going to proceed in life to survive comfortably; and, finally whether or not they are going to continue the problem of having more children. I understand that's a growing problem.

I just made a general statement and would like you to comment. I'm most concerned about these problems.

Mr. Soloway. I'd like to comment about your situation in Houston, because there's one that's very similar in New York City with our School for Pregnant Girls that has a curriculum that's not up to standards of other schools, and also there's a tendency to push out pregnant and parenting youngsters from schools in New York and I'm sure throughout the rest of the country.

I would indicate that that's a clear title IX violation, which, if brought to the proper authorities, ought to be remedied. Of course, in this administration, it's difficult to get any kind of enforcement.

Then we've got a problem that the Legal Services Corporation has less money to take these issues to court, and I know that you missed my prior comments——

Mr. Leland. And I apologize.

Mr. Soloway. No, I didn't mean it that way.

I guess my point is that as the Congress goes about doing a lot of things, it has unintended consequences.

For instance, though I know that the Congress is a big supporter of the Legal Services Corporation, and one of the reasons that the conditions exist in Houston and New York City is simply because the poor and the advocates can't get access to legal remedies, which we need.

I guess if I wanted to say anything to you today, it's that as every piece of legislation gets passed to Congress, one has to see it being passed in terms of what young people need, not only in terms of teen pregnancy but dropouts and other kinds of things, and that we should be very aware of that as we pass legislation.

Mr. LELAND. Dr. Burt?

Ms. BURT. Yes. I think we tend to—because these children are school age, we tend to think that the schools ought to be the places that should be able to help them out of whatever situation they're in, and I think that that's an appropriate expectation for the schools in terms of "shoulds" but not terribly realistic in terms of school system behavior to date.

What tends to happen in many, many districts, as you have remarked, is that kids are sort of discouraged. They can't be legally kicked out any more; but they don't get pursued for truancy for other kinds of things; and they get encouraged to do home study, which basically means they drop out.

If there is a special school, you're actually ahead of most districts in having a special school, but what happens with a lot of special schools is that they are academically less adequate. They provide a nice supportive atmosphere for the girls, and they manage to keep them in school through the pregnancy frequently, but it's then very hard. There's sort of a cliff at the end where, now you have a 2-week-old baby and no school, because you're supposed to go back to your regular school, and you have no supports in your regular school, and you have no child care, et cetera.

So there are real arguments now in terms of how to structure programs to keep kids in regular school, to mainstream them, so that they don't lose the academic aspects of the regular school, and to offer them supports and after-school programs, and day-care in schools, which I think are really important kinds of things to push.

Also, I think some of the best programs in schools are ones which the school system is not paying for or controlling, but which they are simply offering the forum for. Some of the comprehensive health programs, many of which have day-care components to them, are some of the most effective ways to help teenagers stay in their regular schools.

Mr. LELAND. Doctor, let me ask you this. You've raised my interest even more.

I have had in my mind what the Houston Independent School District ought to do, for instance, for developing a model program. I believe that they should develop a comprehensive educational program that would provide for quality education for these youngsters, not enter them into the mainstream, so to speak, because once they are pregnant and once they have had a child, they are not necessarily in the mainstream any more. But, rather HISD should continue the quality education program and, at the same time, have adjunct to that day-care for those young mothers too, during the time of day that they're at school, go right next door and learn to care for those children properly and have comprehensive, adequate health services there available to them over the long term. This way they will not only be able to become productive citizens themselves and learn how to take care of their unique situation, but also help to nurture those children in an environment that is wholesome, to give both the mother and the child an opportunity to advance in society in a very comfortable way.

Hopefully, the child who has had the baby will eventually graduate from school knowing how to care for the children and have some real understanding about the uniqueness of her existence, and then go on to advanced educational programs.

Is that good or bad?

Ms. **Burt**. Oh, I certainly can't say it's bad. I would think it would be wonderful if you could pull it off, but I think it's also very important to recognize that the schools have, in many instances, failed the girls who get pregnant long before they get pregnant. So it's not a simple solution.

I mean you could say to the school districts, "Look; take every girl and every boy who is 2 years behind grade level in the sixth grade, and do something with them so that their life chances are not jeopardized, as we know that they will be, and then they won't get pregnant."

Take the eighth grade; take any grade; and focus on those children who are at high risk of everything bad that we know that happens to children. Pregnancy is just one of those.

Mr. **Leland**. I'm giving them the easy way out.

My colleague, Mr. Scheuer, would agree that we ought to try to prevent this explosion in population, if you will, for whatever reasons. But, I would say—these kids have already gotten pregnant; I'm dealing with the reality of the pregnancies now. They're already pregnant; what are we going to do with them? Are we going to let them go on and drop out of school, as so many of them are doing?

Ms. **Burt**. No—right.

I think that it's very important to structure school programs that recognize the contingencies of their lives, that they cannot always be there 8 hours a day on a regular basis, and that flex with them and their needs, and also teach them good parenting skills. I think that is important.

Mr. **Leland**. Thank you.

Thank you, Mr. Chairman.

Mr. **Scheuer** [acting chairman]. Just one last question, because we do have a rollcall vote coming up.

You mentioned, Dr. Burt, in your testimony, that discussions between parents and kids seem to assist in the process of delaying sexual activity.

Do you have any data as to whether those discussions are discussions that flow from just improved, and sound, and meaningful child-parent relations over the long term, or whether they result from involuntary discussions as a result of parent notification requirements?

Ms. Burt. They tend to be a reflection of good relations with parents.

As Dr. Forrest suggested, there's a whole complex of family variables that go along with or are correlated with delayed sexual activity and also better contraception.

So it is certainly not a result of forced discussion or even a result of one-time "let's talk about this," because usually those come too late.

When you ask teenagers and you ask parents separately whether they have talked about sex, very frequently the teenagers who are higher pregnancy risk report that they have not talked about it, and their parents report that they have. What the teenagers are actually saying is, it was 2 years too late.

So that a one-time conversation is not what we're talking about here. What we're talking about is better parent-child interaction, better relationships, and a more supportive family, and they also talk about sex more, and they also don't have as high pregnancy rates.

The programs that attempt to improve parent-child communication just around sex, without doing all the rest of that, don't, at least to date, seem to have an effect on sexual behavior.

Mr. Scheuer. Well, thank you very much.

Both of these witnesses have given us very stimulating and thoughtful testimony, as have the other panels, and we're grateful to you all. It's been a very productive and rewarding hearing.

We will keep the record open for 1 week or 10 days. We may have some additional questions to ask you by mail.

I would also ask unanimous consent that a brief synopsis of the results of the hearing that we had last week on religious perceptions about family planning, sex education, and so forth be included at the appropriate point.

There being no objection, it is so ordered.

[The information follows:]

On April 24, 1985 members were briefed on religious perspectives on population policy. The briefing was sponsored by the Development and Population Task Force of the Arms Control and Foreign Policy Caucus to help Members sort through the elements of this increasingly intense and emotion-laden public debate.

The program consisted of three presentations which provided information on how people of various religious affiliations feel about population related questions. Dr. Tom Smith, Senior Study Director of the National Opinion Research Center of the University of Chicago, examined shifting attitudes towards family planning. He related these views to a broader set of social attitudes, such as those cn national defense, religion and civil liberties. Dr. Thomas Shannon, professor of social ethics at Worchester Polytechnic Institute, discussed ethical dilemmas in population policy. He presented religious teachings on artificial contraception, and related these teachings to other dilemmas concerning population policy. Olga Lucia Toro, Executive Director of the Centro de Informacion Recursos para la Mujer in Bogota, Colombia, provided a rationale for the extensive involvement of major religious groups in providing family planning information and services in developing countries. Excerpts from their presentations which are pertinent to this hearing on teenage pregnancy follow.

Contrary to "conventional wisdom," Americans are not becoming more conservative on sexual and reproductive matters. There is no evidence that the movement in the last generation toward greater individual freedom in these areas is being reversed. Indeed, by large majorities, Americans favor the provision of birth-control information to both adults and teenagers, support sex education programs in schools, and find it acceptable, at least in some instances, for unmarried adults to live together.

Only on such issues as divorce and childbearing is there some evidence of a return to conservative attitudes. The trends for both behaviors and attitudes regarding childbearing and divorce do support the theory of a movement back towards traditional, family values and structures. After dropping sharply beginning in the late fifties, the birth rate bottomed out in 1975-76 and began to rise in the late seventies and early eighties. Likewise, the proportion of Americans favoring large families (3 or more children) stopped its precipitous decline in 1976 and has stayed at a historically low, but stable level. A similar pattern emerges when we look at divorce. The divorce rate started to rise slowly in the early sixties and continued an uninterrupted increase until 1979. Since then the divorce rate has fallen, although it is still at near record-high levels. Public support for more lenient divorce laws has also dropped. Support for easier divorce increased substantially from 1967 to 1974 and then began to decline as no-fault divorce and other simplification measures were instituted.

If the claims of a traditional resurgence were limited to these areas, they would rest on solid, empirical grounds. But the claims have gone far beyond these modest reversals to include such "family"—related issues as women's rights, sexual morality, family planning, and sex education. And it is on these family issues that the alleged conservative tide runs dry.

On most of these "family" issues, support for liberal positions has grown substantially over the last twenty years and now a solid majority of Americans favor liberal positions. In the area of sexual morality, Americans have become more permissive. Premarital sex has become steadily more acceptable to the public since the sixties. By 1983, 63 percent viewed premarital sex as appropriate, at least in some instances. Even living together (or POSSLQ—people of the opposite sex sharing living quarters—as the Census demurely calls it) has become common, having increased more than three-fold from 1970 to 1983. The public has also become more supportive of the dissemination of information about birth control. By 1983, 92 percent favored allowing adults to have access to birth control information; 87 percent approved of allowing teenagers access to birth control information; and 83 percent supported sex education in the public schools.

There has been no reversal of liberal positions on sexual and reproductive practices; indeed, support is higher for those positions than it was in the early seventies or sixties, and in most cases, a large majority of the public backs the liberal position.

A standard corollary of the belief in the resurgence of conservative attitudes is the belief that this reversal is rooted in religious conservatism. The Catholic Church offically condemns the use of artificial contraceptives as being against the laws of God and nature and therefore a grave sin. However, the notion that Catholics form a bastion of traditionalist strength on sexual and reproductive issues is erroneous (Table 1). Catholics are more liberal than Protestants on approving of premarital sex and sex education. Catholics and Protestants do not differ in their support for dissemination of birth control information to adults or teenagers.

This declining difference between Catholics and Protestants on reproductive attitudes, shows even more clearly on the personal use of contraceptives (Table 2). In 1965 Catholics were less likely to practice contraception than Protestants, and among those who practiced contraception Catholics were much more likely to use the church-sanctioned rhythm methods than were Protestants. By 1976, however, 68 percent of both Catholics and Protestants used contraceptives, and only 9 percent of Catholics (and 4 percent of Protestants) relied on the rhythm method.

In sum, there are only small differences on reproductive attitudes and behaviors of Catholics and Protestants, and Catholics tend to be more liberal rather than more conservative than Protestants. Majority of both married and unmarried Catholics practice birth control methods unsanctioned by the church. Catholic and Protestant flocks do not follow the lead of the church or of the Moral Majority on sexual and reproductive matters.

In addition, the Church's opposition to the use of artifical contraception has been criticized by bishops in many countries as well as by theologians around the world. Bishops in Belgium, France, Canada, the Netherlands, West Germany, Austria, Scandinavia, and Italy, for example, have asserted that the decision to use artifical contraceptives is a matter of personal conscience and that Catholics who make that choice should not be considered unfaithful or sinful.

In the area of international assistance, there is substantial support for the inclusion of family planning assistance as part of the general aid package with very little difference between Catholics and Protestants (Table 3). Both groups consider overpopulation to be a serious and enduring problem and a hindrance to economic development. While many Americans do not support foreign aid in general (in 1984, 75 percent thought too much was being spent), there is little opposition to family planning assistance. Opposition to foreign aid is strongest against military aid. Catholics, in particular, are opposed to both military assistance to the Third World (66 percent of Catholics opposed such aid compared with 50 percent of Protestants) and American military spending in general (in 1984 54 percent of Catholics thought too much was being spent on the military compared with only 33 percent of Protestants). In general, most Catholics and Protestants support family planning aid.

On sexual and reproductive issues, then, there has not been a resurgence of conservative attitudes. The movement over the last generation has been towards greater individual freedom in these areas, and none of these trends have been reversed in recent years. While the Pope and Moral Majority take very traditional stances on these matters, their positions are overwhelmingly rejected by the majority of Catholics and Protestants, respectively. Likewise traditionalist positions on sexual and reproductive measures do not appreciably shape public attitudes on international family planning assistance. Catholics and Protestants have very similar positions. Both support family planning assistance, although the public is generally supportive of foreign assistance in general.

TABLE 1—RELIGIOUS DIFFERENCES ON SEXUAL AND REPRODUCTIVE ISSUES

	1974	1975	1977	1978	1982	1983
A. Birth control information for adults (percent favoring):						
Protestants	92.0	91	93.0		92.0	91.0
Catholics	92.0	90	91.0		92.0	92.0
B. Birth control information for teenagers (percent favoring):						
Protestants	78.0	80	83.0		86.0	86.0
Catholics	80.0	77	82.5		88.0	85.5
C. Sex education in public schools (percent favoring):						
Protestants	78.0	77	77.0		83.0	85.0
Catholics	87.0	80	80.0		86.0	88.0
D. Premarital sex (percent believing it is not always wrong):						
Protestants	61.5	65	66.0	65	65.5	66.0
Catholics	71.5	72	70.0	77	78.0	80.0

Source: General Social Surveys, National Opinion Research Center, University of Chicago. GSS:60

TABLE 2.—RELIGIOUS DIFFERENCE IN CONTRACEPTIVE USAGE

[In percent]

	1965	1973	1976
Contraceptive status of white married women, 15 to 24:			
Catholics:			
No contraception	12	10	9
Pregnant or seeking pregnancy	21	17	13
Infertile/sterile	10	7	10
Using contraceptive	57	66	68
Protestants:			
No contraception	8	7	6
Pregnant or seeking pregnancy	13	13	13
Infertile/sterile	13	8	13
Using contraceptive	66	72	68
Protestant-Catholic percent using contraceptive	+11	+6	0
Use of rhythm method among white married women, 15 to 44 who use some contraceptive:			
Catholics: percent using rhythm	32	8	9
Protestants: percent using rhythm	4.5	3	4
Protestant-Catholic percent using rhythm	27.5	5	5

Source: "Trends in Contraceptive Practice: United States, 1956–1976," Vital and Health Statistics, Series 23, No. 10., Washington, D.C.: National Center for Health Statistics, 1982.

	Men	Women
Contraceptive status of sexually active but unmarried men and women, 18–24 in 1982:		
Catholics:		
No contraceptive	28	14
Pregnant/partner pregnant	1	2
Ineffective methods [1]	13	11
Effective methods	58	73
Protestants:		
No contraceptive	23	13
Pregnant/partner pregnant	1	4
Ineffective methods	13	9
Effective methods	63	74

[1] Ineffective methods consist mostly of rhythm methods, but also include withdrawal and douches.

Source: National Longitudinal Survey of Youths, National Opinion Research Center.

TABLE 3.—RELIGIOUS DIFFERENCES ON OVERPOPULATION AND FAMILY PLANNING ASSISTANCE ISSUES

[In percent]

	Catholics	Protestants
A. Percent believing overpopulation will be serious problem 25 to 50 yr from now (Roper, December 1982)	51	54
B. Percent believing that high birth rates hurt economic growth (Gallup, July 1984)	83	83
C. Percent approving of U.S. aid to poor countries to reduce population growth (Gallup July 1984)	51	57
D. Percent thinking that more than 5 percent of foreign aid should go to family planning (Gallup, July 1984)	40	33
E. Percent believing that population control be a condition for foreign aid (Gallup, July 1984)	34	38
F. Percent believing that health programs in Third World should include family planning (Gallup, July 1984)	79	83

Sources: Roper Reports 83-1 and Segal, Sheldon J., "U.S. Population Assistance to Developing Countries," August 1984.

Mr. SCHEUER. Thank you all very much. The hearing is adjourned.

[Whereupon, at 3:55 p.m., the subcommittees were adjourned.]

[The following statement of Congresswoman Cardiss Collins was received for the record. Also included is a paper prepared for the Subcommittee on Census and Population and submitted by the Alan Guttmacher Institute entitled, "Hispanic Teenagers: A Reproductive Profile."]

STATEMENT OF HON. CARDISS COLLINS, A MEMBER OF CONGRESS FROM THE STATE OF ILLINOIS

I want to commend Chairman Waxman and Chairman Garcia for convening today's hearing on a problem that is both national in scope and epidemic in proportion. As a member of the Health and Environment Subcommittee, the Congressional Caucus for Women's Issues, and the Congressional Black Caucus, I have a strong and continuing interest in the matter before us today.

There are currently over 1 million teenage pregnancies being reported in this country each year and the number is rising. In 1982, my home State of Illinois reported that 16.2 percent of all births were to women under age 20 and 63.7 percent of those were born out of wedlock.

As tragic as these statistics are, the real life consequences are even more dramatic and compelling. This problem impacts on the stability of our Nation's families, leads to an increased drop out of rate among teenage girls from school and reduced employment opportunities, and poses a threat to the very health of our newborn.

In hearings before Congressman Waxman's Health Subcommittee last month, we heard testimony bearing out the nature and extent of this problem, one that disproportionately afflicts members of the black and Hispanic communities. Maternal mortality rates for black teens, we were told, are 4 times as high as for white teenagers, which overall is 17 percent higher than for women in the 20–24 age group.

As I said, infants also bear the brunt of the teenage pregnancy problem. Due to poor prenatal care and nutrition, these infants tend to have lower birth rates and thus are at greater risk of death. Projections reveal that by the end of this decade, some 22,000 babies will die in the U.S. due to prematurity.

What's the answer? A key element in dealing with this national tragedy is education and family planning facilities, both for teenage mothers as well as for their families. To this end, I have joined with two of my colleagues, Mr. Leland and Mr. Garcia, in sponsoring two bills—the "Adolescent Pregnancy and Parenthood Act" (H.R. 927) and the "Comprehensive Adolescent Pregnancy Program Amendments" (H.R. 947). This legislation would, in my judgment, make significant strides in solving this serious and chronic problem.

Today's hearing should help to build a solid record upon which the Congress and hopefully the Administration will act to deal with this grave situation. I appreciate the opportunity to be present at this afternoon's session, and I look forward to the testimony of the witnesses.

Let me again express my thanks to both of the Chairmen for their continued interest and attention to this issue.

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Hispanic Teenagers: A Reproductive Profile

Submitted to the
House Subcommittee on Census and Population
The Honorable Robert Garcia, Chairman

May 15, 1985

SUMMARY

- Hispanic teenage women are more likely than either non-Hispnaic whites or blacks to have been married: About one-fifth of Hispanic women aged 15-19 have been married, compared to less than one-tenth of non-Hispanics in this age group.
- However, among the never married, sexual activity is somewhat lower for Hispanics than for whites and much lower than for blacks.
- Altogether, about one-half (50 percent) of all Hispanic teenage women have ever had intercourse, compared to 44 percent of whites and 59 percent of blacks.
- Currently, one-third of Hispanic and non-Hispanic white teenagers and 46 percent of black teenagers are exposed to the risk of unintended pregnancy.
- Less than one-quarter of Hispanic teenage women who have ever had intercourse used contraception the first time they had intercourse. Higher proportions of non-Hispanic whites and blacks used some method at first intercourse. For all three groups, the pill was used by a very small proportion and the majority of contraceptors used less effective methods (chiefly the condom and withdrawal).
- Of those currently exposed to the risk of unintended pregnancy, two-thirds of Hispanics and blacks and three-fourths of non-Hispanic whites are practicing contraception. The pill is by far the most popular choice, with six-tenths to seven-tenths of current users choosing this method.
- However, more than one-half of those exposed to the risk of unintended pregnancy are using less effective methods or no method at all. Among Hispanics one-third of those exposed are not practicing contraception and another one-fifth are using less effective methods.
- Hispanic teenagers using contraception are more likely to use private physicians and less likely to use clinics than white teenagers. Black teenagers using contraception are most likely to use clinics.

- Fertility among Hispanic teenagers is higher than among white teens, but lower than among black teens. In 1980 the rate for Hispanics was 82 per 1000, compared to 41 for non-Hispanic white teens and 105 for non-Hispanic black teenagers.
- The level of Hispanic teenage fertility varies among the states. States whose Hispanics are mainly Mexican have a relatively high rate for Hispanics (85 or more per 1000). States with Puerto Ricans predominating among their Hispanics have a somewhat lower level (65-74 per 1000). The one state with a Cuban and Caribbean concentration among Hispanics, Florida, has the lowest level of Hispanic teen fertility (41 per 1000) which is almost the same as that of the white population in Florida.
- The rate of out-of-wedlock childbearing is quite high among Hispanic teenagers (40 per 1000), which is more than twice the level for white unmarried teens (16), but is less than half the level for black teenagers (89).
- Hispanic and black teenage mothers have about the same chance of having inadequate prenatal care (visits to the doctor starting later than the sixth month of pregnancy or no visits at all). They are both much worse off than non-Hispanic white teenage mothers.

Introduction

The high level of pregnancy among American teenagers is a matter of concern for the entire society. Statistics for the entire teenage population often mask, however, differences by subgroup that might help in understanding and in shaping policies and programs to address the problem. While it has been generally known that black teens have higher pregnancy rates than whites, other differences and similarities between the two groups have been less clearly understood. (It is clear, however, that even white adolescents in the U.S. have pregnancy rates much higher than teens in comparable countries such as Canada, England and Wales, France, The Netherlands and Sweden (Jones et al, 1985). Even less is known about the levels and patterns of pregnancy and pregnancy-related behavior among Hispanic adolescents or among subgroups of the Hispanic population.

Basic information about fertility levels and patterns among Hispanics has already been compiled (AGI, 1984). Since completion of that review of published data some additional information has become available and the Alan Guttmacher Institute has carried out special analyses of two important new surveys, the National Survey of Family Growth (NSFG), carried out by the National Center for Health Statistics (NCHS) in 1982, and the National Natality Survey (NNS), carried out by NCHS providing data on a large sample of the births that occurred during 1980. This report expands on the earlier review, by providing new data comparing Hispanic, black, white and other adolescents in their levels of exposure to the risk of childbearing, contraceptive use, and use of family planning sources and their birth rates and use of prenatal care. Data on birth rates are presented by state.

The data cover the period 1980-1982, with the exact year depending on the data source. In some cases, more recent data than available in the previous report are presented, and in other cases the data could not be updated, but greater detail is now available. Changes during this time period have been minor and the data presented here and in the earlier report can be confidently compared even if the years differ slightly.

Most published statistics provide separate distributions by race (white, black, other) and by ethnicity (Hispanic, non-Hispanic). In such cases, the "white" and to a lesser extent the "black" groups contain Hispanics as well as non-Hispanics. Since most whites and blacks in the U.S. are non-Hispanics, the total "white" and "black" statistics are close to the levels for non-Hispanics. In calculations made from survey data by the AGI, different distributions have been used - Hispanic, non-Hispanic blacks and non-Hispanic whites and others.

Exposure to Risk of Unintended Pregnancy

Marital Status

As shown in Table 1, one in five Hispanic women aged 15-19 has been formally married or considers herself married. Sixteen percent are currently living with their spouse or partner; about four percent are already divorced or separated. The percentage of Hispanics who were ever married (20 percent) is more than twice the percentage for non-Hispanic whites (eight percent) and five times that for blacks (four percent).

Sexual Activity

In addition to the 20 percent of Hispanic teens who have married, another 30 percent are unmarried and have had intercourse as shown in Table 1. Even though Hispanic teens are much more likely than either non-Hispanic whites or blacks to marry, the proportion of Hispanic women aged 15-19 who have never been married and have had intercourse (30 percent) is slightly lower than among whites (36 percent) and much lower than among blacks (55 percent).

Thus, as seen in Table 2, a total of 50 percent of Hispanic women have had sex, compared to 44 percent of non-Hispanic whites and 59 percent of blacks.

Compared to non-Hispanic whites, Hispanics began sex at a relatively young age. In 1982, about 80 percent of Hispanic teenagers aged 15-19 who had had intercourse had done so by age 16, compared to 68 percent of similar whites. Blacks generally initiate sexual activity earlier than either Hispanics or non-Hispanic whites, with a slightly higher proportion (83 percent) who started by age 16 (not shown).

As shown in Table 2, although half of Hispanic women aged 15-19 have ever had sexual experience, only one third are currently exposed to the risk of unintended pregnancy. Currently exposed women are those who are using contraception and nonusers who were sexually active in the three months prior to the survey and were not pregnant, postpartum, seeking to be pregnant, or noncontraceptively sterile, (Bachrach, 1984). Most of the Hispanic and black teenagers who have had intercourse but are not currently exposed to risk were pregnant, postpartum or seeking pregnancy, while comparable whites were more likely not to have had intercourse recently. Hispanics are as likely as whites to be at risk of unintended pregnancy (33 vs 32 percent) even though relatively more have ever had intercourse (Figure 1), because fewer non-Hispanic whites are pregnant, postpartum or trying to get pregnant. Blacks, who are most likely to be sexually active, also have the highest proportion of women aged 15-19 exposed to risk of unintended pregnancy (46 percent).

Use of Contraceptives

As shown in Table 3, less than one-fourth (23 percent) of Hispanic women aged 15-19 with sexual experience used some method of contraception the first time they had intercourse, with the proportion being much higher for non-Hispanic teens -- 36 percent of blacks and 55 percent of whites. Few teens in any group used the pill, the most effective method, but the Hispanic teens were least likely to do so. The higher proportion of blacks than Hispanics using a contraceptive method at first intercourse (13 percentage points higher) was due largely to greater use by blacks of the pill (seven percentage points difference) and of condoms (six percentage points difference). Most of the difference between Hispanics and non-Hispanic whites (32 points) was due to whites' greater use of the pill (six percentage points), the condom (12 percentage points) and of withdrawal (13 points).

The method most commonly used by teenagers in each group who used contraception at first intercourse was the condom — 57 percent of Hispanics and slightly fewer blacks and whites used it (Table 4). After condom, the next most frequently used method was withdrawal among Hispanic and non-Hispanic whites or the pill among blacks; but they were much less popular than the condom. At first intercourse only 11 percent of Hispanics and 16 percent of white contraceptors were using the pill, compared to 30 percent of blacks.

As Table 5 indicates, the use of contraceptives increases dramatically after sexual relationships are begun. At most recent intercourse, 68 percent of Hispanics, 66 percent of blacks and 73 percent of whites who were currently exposed to risk of unintended pregnancy were practicing contraception. Among Hispanics, the increase in method use is due almost entirely to the increased proportion using the pill. For blacks, increased use of the pill in spite of decrease in the proportion relying on the condom led to the steep increase in overall use. Pill use among non-Hispanic whites increased more than overall use because not only did many nonusers adopt the pill but also the proportions using the condom and withdrawal dropped as many switched from these initial methods to the pill.

Among those adolescents using a method at most recent intercourse, the pill is by far the most popular choice: six in 10 of Hispanics and non-Hispanic whites and seven in ten of blacks who were practicing contraception were using the pill (Table 6). The pill was followed by condom as the second most commonly used method. Non-Hispanic white users are more apt to rely on the condom (23 percent) than either Hispanics (15 percent) or blacks (13 percent).

In spite of the improvement in contraceptive status between first and most recent sexual intercourse, more than half of teenagers currently exposed to risk of unintended pregnancy are using less effective methods or none at all. Among Hispanics, about one-third of those exposed to risk were not using a method and another one-fifth were using the less effective methods (see Table 5).

Source of Family Planning Services

As may be seen in the top panel of Table 7, 76 percent of Hispanic and non-Hispanic white women aged 15-19 and 83 percent of blacks who have had intercourse have made a visit to discuss or obtain contraception. A substantial proportion (24 percent) of Hispanics and non-Hispanic whites, as well as 17 percent of blacks, who have had intercourse have not been to a private physician, clinic or counselor for family planning services. As seen in the lower panel of Table 7, about one-half of Hispanic teenagers who have ever visited a family planning provider first went to a private physician for services, compared with 45 percent of white teenagers. Black teenagers were much more likely to go to clinics for their first family planning visit (72 percent) than either Hispanics (49 percent) or non-Hispanic whites (49 percent).

As shown in Table 8, among current contraceptors, some 23 percent of Hispanics, 34 percent of whites and 46 percent of blacks obtained their current method from a family planning clinic first. More Hispanics (51 percent) than whites (41 percent) or blacks (36 percent) reported that they went to a physician for their current method.

Childbearing

Statistics on abortion by ethnic group are not available so that abortion rates and pregnancy rates (births plus abortions) cannot be computed separately for Hispanic adolescents. Birth rates can be calculated, however. As presented in an earlier report (AGI, 1984), in 1980 the birth rate for Hispanic women aged 15-19 was 82 per 1,000. This was higher than the birth rate for all white women (45 per 1,000) and lower than that for all black women (100 per 1,000)

Newly available data allow comparisons at the state level, not only for all Hispanics versus non-Hispanics and versus total whites and blacks, but also for subgroups of Hispanics. Twenty-two states obtain Hispanic origin on the birth certificate, and these 22 states are estimated to have about 90 percent of all Hispanic births (Ventura, 1981). The Hispanic population and Hispanic births are mainly concentrated in nine of these states, however. The nine states (Arizona, California, Colorado, Florida, Illinois, New Jersey, New Mexico, New York and Texas), which reported 5000 or more Hispanic births in 1980, contain 96 percent of all Hispanic births reported in the 22 states or about 86 percent of all Hispanic births in the United States.

As seen in Table 9, about 30 percent of births in California, New Mexico and Texas, 15-23 percent in Arizona, Colorado and New York and about 10 percent in Florida, Hawaii, Illinois, Nevada and New Jersey are to Hispanic mothers. These states vary in the type of Hispanic ethnic group which predominates. It is Mexican in Arizona, California, Illinois, Nevada and Texas, and probably also in Colorado and New Mexico, even though it is the "Other, Unknown Hispanic" category that was reported by most mothers in these two states. Davis et al. (1983) suggest that in the South West the category "Unknown, Other" includes "Hispanics" who trace their origin to Spanish colonialists and Indians who were the original inhabitants of this region. Hispanics in New York and New Jersey are mainly Puerto Ricans, while Florida has a large concentration of Cubans as well as other Hispanics, probably from the Caribbean countries. Since these ethnic groups are known to differ in level of fertility, these state variations in type of ethnic concentration are expected to be related to the level of teenage fertility also.

Birth rates for teenagers in the nine states that have the most Hispanics, are presented in Tables 10 and 11 by race and ethnic subgroup. These rates are the number of births per 1000 women in specific age groups (15-17, 18-19, and 15-19), during 1980. Table 10 shows rates for all women aged 15-19, regardless of their marital status, while Table 11 gives rates for unmarried teenagers - i.e., the number of nonmarital births per 1000 unmarried women. In both cases, rates for all non-Hispanics and separately by race, for all whites and all blacks (each including Hispanics of that race) are presented for comparison with all Hispanics.

The nine states where most Hispanics live show great variations in the level of Hispanic teenage fertility. Looking at rates for all teenagers aged 15-19 in Table 10, the states fall into three groups: those with quite high levels of childbearing where rates are 85 per 1000 women or more (Arizona, California, Colorado, Illinois and Texas); those with moderate levels, rates of 65-74 (New Jersey, New Mexico and New York); and one state with almost the same level as the average rate for the white population (Florida, with a rate of 41 per 1000 women). These groups roughly coincide with the type of Hispanic ethnic concentration. Mexican origin concentrations coincide with the highest rates, except for New Mexico, where the "other, unknown Hispanic" majority is apparently demographically different from groups which directly report themselves as Mexican in origin. States with Puerto Rican concentrations have only moderate overall teenage fertility, while the one state with a Cuban and Caribbean origin concentration (Florida) has a relatively low level of teenage childbearing. These group differences are not so strong at ages 15-17 as for the birth rates of 18-19 year-olds.

Fertility among unmarried Hispanic women does not show the same differences across states. As seen in Table 11, three states, Florida, New Mexico and Texas have relatively low levels of out-of-wedlock childbearing (14-27 births per 1000 unmarried women aged 15-19), while all of the others, some with Mexican and two with Puerto Rican majorities among Hispanics, have much higher levels (45-49 per 1000). Clearly, except possibly for Florida, factors other than ethnicity are influencing the levels of teenage non-marital fertility among Hispanics.

It is also interesting to compare Hispanic fertility with levels for non-Hispanics, and with rates for whites and blacks. This comparison can be made with the actual rates in Tables 10 and 11 and with Figures 2 and 3. The average for all 22 states where data are available by ethnicity shows that at age 15-19 the birth rate for Hispanics (82 per 1000) is about 80 percent of the rate for non-Hispanic blacks (105 per 1000), and twice that of non-Hispanic whites (41 per 1000). As seen in Table 11, unmarried Hispanic women aged 15-19 have an even lower level of fertility compared to the total black teenage unmarried population (45 percent of the black non-marital birth rate). The overall white rate of out-of-wedlock childbearing is lower than that of Hispanics, about 40 percent of the Hispanic rate and 18 percent of the black rate.

These overall patterns do not characterize all states, however (see Figure 2). In four states (California, Colorado, New York and Texas), Hispanic and black fertility rates are even more similar (Hispanic birth rates are 88-98 percent of black levels) than the overall 22-state average. In two states (Florida and New Mexico) Hispanic fertility is much the same as that of whites, and is a much smaller proportion of black levels (33 and 64 percent, respectively) than the overall 22-state level of 80 percent. In the case of New Mexico, the fact that Hispanics, who are usually included in the white race category, contribute about 40 percent of white births explains some of the similarity between Hispanics and whites. In 3 of these 9 states, the level of non-marital teen fertility among Hispanics is more similar to that of blacks than the nationwide average of 45 percent (61 percent of the black non-marital rate, in California and 71-72 percent of the black rates in Colorado and New York).

Childbearing among younger teens, aged 15-17, is of more concern to policy makers than that among older teens because of the more serious implications in regards to completion of even a high school education, and also in regards to the health of the mother and child. The rate of childbearing among young teens is by no means negligible among Hispanics (52 births per 1000 girls in 1980) and non-Hispanic blacks (77 per 1000), but is much lower among non-Hispanic whites (22 per 1000). These levels of fertility for young teens are compared with the level of older teens (18-19) in Figure 3, since the actual rates are important in evaluating the extent of the problem of teenage fertility.

Hispanic 15-17 year-olds have about 41 percent of the level of childbearing of 18-19 year-olds, compared to 52 percent among blacks and 32 for whites. This suggests that the concentrations of adolescent fertility among the younger teens, with the accompanying greater degree of problems, is less marked among Hispanics than among blacks, but more severe than for whites.

Among the states, 15-17 year-old Hispanics have as little as 33 percent of the 18-19 fertility rate in Florida, but most states cluster around the average of 41 percent. In Colorado and New York, Hispanics are much the same as non-Hispanic blacks in this comparison, while in Florida, Illinois and New Mexico, they are very similar to the white population.

For all ethnic/race groups unmarried childbearing among teens is relatively more concentrated at ages 15-17 than is total childbearing. Among Hispanics, young teens have 46 percent of the rate of non-marital fertility of older teens, compared to 41 percent for overall fertility. This comparison is 54 percent versus 39 percent, for all non-Hispanics, 58 percent versus 53 percent for the total black teenage population, (most of whom are not Hispanic), compared to 50 versus 35 percent for the total white population.

The average number of children born to 1000 teenagers during ages 15-19, 15-17 and 18-19 is another meaningful way of comparing ethnic differences in levels of childbearing. These results are shown in Table 12. On average, every 1000 Hispanic teens will have 410 children by the time they turn 20, compared to 205 children for 1000 white non-Hispanic teens and 525 for 1000 black non-Hispanic teens. This rate is not exactly equivalent to saying that 41 out of every 100 teens had become mothers during ages 15-19, since individuals may have more than one child during these years. Among Hispanics nearly 40 percent of these 410 children are borne by young teenagers, compared to 44 percent among non-Hispanic blacks and 32 percent among non-Hispanic whites. As shown in Table 12 states vary in their absolute levels, and in the comparison with the white and black populations.

Prenatal Care

Information on prenatal care among Hispanic mothers may be obtained from birth certificates for the 22 states which record Hispanic origin of mother. Among Hispanic mothers of all ages, the percent of women who began prenatal care too late in the pregnancy (care is considered to be inadequate if it starts later than the sixth month or if there is no care at all) has declined slightly, from 1980 to 1981 (Table 13).

For all Hispanic ethnic groups, except Cubans, these data show a slight improvement in the receipt of care. These data also show that mothers whose ethnic origin is Puerto Rican have the least adequate care, followed by Central and South American, and Mexicans. It is quite likely that teenagers would have similar ethnic differences in the proportion receiving inadequate prenatal care.

In the 22 reporting states Hispanic teenagers are somewhat worse-off than non-Hispanic black teens, and much worse-off than non-Hispanic white teenage mothers with regard to adequacy of prenatal care (see Table 14). These differences are found in each age-group, except those less than 15, among whom whites have the greatest proportion with inadequate care. Data on births to women of all ages in the 22 reporting states in 1980 and 1981 also indicate that Hispanics are slightly worse-off than blacks and much worse-off than whites, in adequacy of prenatal care (Ventura, 1983 and 1984). However, a national survey of mothers in 1980 shows a different pattern among all teenage mothers, with non-Hispanic blacks being slightly worse-off than Hispanics (see Table 14). The rates from this survey are based on small sample sizes and these estimates have quite large sampling errors. The sample variation of the national survey's estimate accounts for most of the apparent difference between the 1980 national estimates and the 1981 22-state figures.

We may conclude from these different sources however, that Hispanics and non-Hispanic blacks are not widely indifferent but both groups have much higher proportions with inadequate prenatal care than do non-Hispanic whites.

Unmarried teenage mothers of all ethnic and racial groups are much more likely than married mothers to have inadequate prenatal care. Among Hispanic teens, seven percent of married mothers receive inadequate prenatal care, compared to 20 percent of those who are unmarried.

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Source for tables 1-8:

Source: Alan Guttmacher Institute (AGI), tabulations from the National Center for Health Statistics, 1982 National Survey of Family Growth.

Table 1: Number and Percentage Distribution of Hispanic and Non-Hispanic Women Aged 15-19 by Marital Status and Whether They Have Experienced Intercourse, 1982.

Marital Status and Intercourse Experience	Total	Hispanic	Non-Hispanic Black	Non-Hispanic White & Other
No. of women (in 000's)	9,521	886	1,383	7,251
Total	100	100	100	100
Ever married	9	20	4	8
Formally married	6	12	3	6
Informally married	2	4	1	1
Separated/Divorced/Widowed	1	4	*	1
Never Married	91	80	96	92
Ever had intercourse	38	30	55	36
Never had intercourse	53	50	41	56

* Less than 0.5 percent

Note: Percentages may not add to 100 due to rounding

Table 2: Number of Hispanic and Non-Hispanic Women Aged 15-19 and the Percentages Who Ever Had Sexual Intercourse and Who Are Currently Exposed to the Risk of Unintended Pregnancy, 1982.

Status	Total	Hispanic	Non-Hispanic Black	Non-Hispanic White & Other
No. of women (in 000's)	9,521	886	1,363	7,251
Ever had intercourse	47	50	59	44
Not exposed	13	17	14	12
Pregnant, postpartum, seeking to be pregnant, or noncontraceptively sterile	7	10	10	6
Not using contraception and not sexually active in last 3 months	6	7	4	6
Currently exposed*	34	33	46	32

* Women exposed to the risk of unintended pregnancy include those who were currently practicing contraception, and those not currently practicing contraception who had intercourse in the last 3 months and were not any of the following: pregnant, postpartum, seeking pregnancy, or noncontraceptively sterile (Bachrach, 1984).

Table 3: Number and Percentage Distribution of Hispanic and Non-Hispanic Women Aged 15-19 Who Ever Had Sexual Intercourse by Contraceptive Method Used at First Intercourse, 1982

Contraceptive method used at first intercourse	Total	Hispanic	Non-Hispanic	
			Black	White & Other
No. ever had intercourse (in 000's)	4,467	442	814	3,211
Total	100	100	100	100
Used contraception at 1st intercourse	48	23	36	55
More effective method	9	4	11	9
Pill	8	3	11	9
Other (IUD, Male Sterilization)	1	2	*	1
Less effective method	39	19	25	46
Condom	22	13	19	25
Withdrawal	13	4	5	17
Other	4	2	2	4
Did not use contraception at 1st intercourse	52	77	64	45

* Less than 0.5 percent

Table 4: Number and Percentage Distribution of Hispanic and Non-Hispanic Women Aged 15-19 Who Used a Contraceptive Method at First Intercourse, by Type of Method Used, 1982.

Contraceptive method used at first intercourse	Total	Hispanic	Non-Hispanic Black	Non-Hispanic White & Other
No. who used a method (in 000's)	2,152	101	292	1,759
Total	100	100	100	100
More effective method	19	19	30	17
Pill	17	11	30	16
Other (IUD, Male Sterilization)	2	8	*	1
Less effective method	81	81	70	83
Condom	47	57	52	45
Withdrawal	27	17	13	30
Other	8	7	6	8

* Less than 0.5 percent

Table 5: Number and Percentage Distribution of Hispanic and Non-Hispanic Women Age 15-19 Currently Exposed to the Risk of Unintended Pregnancy, by Current Contraceptive Status, 1982.

Contraceptive method currently used	Total	Hispanic	Non-Hispanic	
			Black	White & Other
No. currently exposed (in 000's)	3,244	290	630	2,324
Total	100	100	100	100
Using contraception	71	68	66	73
More effective method	47	49	49	46
Pill	46	43	46	46
Other (IUD, Sterilization)	1	6	3	0
Less effective method	24	19	16	27
Condom	15	10	9	17
Diaphragm	4	3	1	5
Rhythm	2	3	2	1
Other	4	2	5	4
Not using contraception	29	32	35	27

Note: Percentages may not add to 100 due to rounding.

Table 6: Number and Percentage Distribution of Hispanic and Non-Hispanic Women Aged 15-19 Exposed to the Risk of Unintended Pregnancy Who Currently Used a Contraceptive Method, by Type of Method Used, 1982.

Contraceptive method currently used	Total	Hispanic	Non-Hispanic	
			Black	White & Other
No. (in 000's)	2,302	197	413	1,692
Total	100	100	100	100
More effective method	66	72	75	63
Pill	64	63	70	63
Other (IUD, Sterilization)	2	9	5	0
Less effective method	34	28	25	37
Condom	21	15	13	23
Diaphragm	6	5	2	7
Other	8	8	10	7

Note: Percentages may not add to 100 due to rounding.

Table 7 Number and Percentage Distribution of Hispanic and Non-Hispanic Women Aged 15-19 Who Ever Had Sexual Intercourse and Who Ever Made a Family Planning Visit, by First Source of Family Planning Services, 1982.

			Non-Hispanic	
First Source	Total	Hispanic	Blacks	White & Other
Ever had intercourse				
No. (in 000's)	4,467	442	814	3,211
Total	100	100	100	100
Made a visit	78	76	83	76
Physician	32	37	21	35
Clinic	41	37	60	38
Counselor	4	2	3	4
Made no visit	22	24	17	24
Made a family planning visit				
No. (in 000's)	3,468	334	678	2,457
Total	100	100	100	100
Physician	42	49	25	45
Clinic	53	49	72	49
Counselor	5	3	4	6

Note: Percentages may not add to 100 due to rounding.

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Table 8 Percentage Distribution of Hispanic and Non-Hispanic Women Aged 15-19 Who Were Exposed to the Risk of Unintended Pregnancy by First Source of Current Contraceptive Method Used, 1982.

First source of current method	Total	Hispanic	Non-Hispanic Black	Non-Hispanic White & Other
No. currently using contraceptives (in 000's)	2,302	197	413	1,692
Total	100	100	100	100
Physician	41	51	36	41
Clinic	35	23	46	34
School	10	10	5	11
Other	8	4	7	8
None	6	12	6	5

Note: Percentages may not add to 100 due to rounding.

Source: Alan Guttmacher Institute, tabulations from the National Center for Health Statistics, 1982 National Survey of Family Growth.

Table 9 - Percentage Distribution of live-births by Hispanic Origin of mother and by race of child for mothers of non-Hispanic origin : 22 Reporting States, 1980.

22 Reporting States	Number of Live births	Percent Distribution By Ethnicity								
		Hispanic					Non-Hispanic			
		Total	Ethnic Origin - Mother				Total	Race of Child		
			Mexican	Puerto Rican	Cuban	Other Unknown		White	Black	Other
Arizona	50,048	23.1	22.1	0.1	0.0	0.9	76.9	62.0	3.9	11.0
Arkansas	37,278	0.7	0.2	0.0	0.0	0.4	99.3	73.8	24.6	0.9
California	40,2949	28.5	25.0	0.3	.1	3.0	71.5	54.4	9.9	7.2
Colorado	49,730	14.7	6.5	0.1	0.0	8.0	85.3	77.6	4.7	3.0
Florida	131,795	9.0	1.4	1.1	3.4	3.0	91.0	64.6	25.4	1.0
Georgia	923,313	0.7	0.2	0.2	0.0	0.3	99.3	61.8	36.6	0.9
Hawaii	18,161	9.9	1.2	2.9	0.0	5.7	90.1	21.7	3.1	65.3
Illinois	190,058	9.4	5.9	1.4	0.1	2.0	90.6	66.9	21.7	2.0
Indiana	88,440	1.9	1.3	0.3	0.0	.3	98.1	86.5	10.9	0.7
Kansas	40,716	3.2	2.5	0.2	0.0	.5	96.8	86.2	8.3	2.3
Maine	16,461	0.3	0.0	0.0	0.0	0.2	99.7	97.9	0.5	1.3
Mississippi	47,845	0.3	0.1	0.0	-	0.1	99.7	51.4	47.5	0.8
Nebraska	27,352	2.4	2.1	0.0	0.0	.3	97.6	90.8	4.7	2.1
Nevada	13,320	8.3	5.2	0.1	0.2	2.8	91.7	75.7	9.8	6.2
New Jersey	96,866	10.6	0.2	6.5	0.9	3.0	89.4	67.4	19.8	2.2
New Mexico	26,115	33.6	8.6	0.1	0.0	24.8	66.4	50.4	2.1	13.9
New York	239,011	13.8	0.3	8.3	0.3	5.0	86.2	64.2	19.1	2.9
North Dakota	11,982	0.4	0.3	-	-	0.2	99.6	91.3	0.9	7.4
Ohio	169,148	1.3	0.5	.4	0.0	0.3	98.7	84.0	13.8	0.9
Texas	273,580	29.1	28.5	0.1	0.0	0.4	70.9	55.3	14.1	1.5
Utah	41,797	4.1	2.3	0.0	0.1	1.7	95.9	92.2	0.5	3.2
Wyoming	10,562	6.3	3.9	0.1	-	2.3	93.7	89.2	1.0	3.5

Source: U.S., Dept. of Health and Human Services, National Center for Health Statistics, "Birth and Fertility Rates for States, 1980," Vital and Health Statistics, Series 21, No. 42, Table 5 pages 22-23.

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Table 10 - Birth Rates(5) for women aged 15-19, by age, ethnicity and race, selected states(1), 1980

	15-19				15-17				18-19			
	Ethnicity		Race		Ethnicity		Race		Ethnicity		Race	
State	Hispanic	Non-Hispanic	White	Black	Hispanic	Non-Hispanic	White	Black	Hispanic	Non-Hispanic	White	Black
Arizona	104	56	60	124	70	33	36	99	157	87	93	158
California	85	44	51	89	52	25	29	60	133	70	82	132
Colorado	89	43	48	91	59	23	27	60	135	69	75	132
Florida	41	61	43	126	23	39	23	97	69	91	70	169
Illinois	91	54	41	122	52	34	22	91	144	82	69	167
New Jersey	74	32	23	97	48	19	12	69	113	52	41	141
New Mexico	68	75	66	107	43	45	41	82	105	119	104	142
New York	65	31	26	74	43	18	14	51	99	50	43	110
Texas	98	67	68	112	66	42	42	84	147	100	104	151
All 22 Reporting States(2)	82	52	41(3)	105(3)	52	31	22(3)	77(3)	127	80	68(3)	147(3)
National Rate(4)	na	na	45	100	na	na	25	74	na	na	72	139

1) States with more than 5,000 Hispanic births reported
2) 22 States report Hispanic origin on the birth certificate
3) Rates are for non-Hispanic whites and non-Hispanic blacks in all 22 reporting states, while rates for the individual states are for all whites and all blacks
4) The total U.S. population
5) Births per 1000 women

Source: U.S., Dept. of Health and Human Services, National Center for Health Statistics, "Birth and Fertility Rates for States, 1980," Vital and Health Statistics, Series 21, No. 42, Table 6, pages 24-25 and Table 2, pages 10-14.

Table 11 - Birth Rates(5) for unmarried women aged 15-19 by age, ethnicity and race, selected states(1), 1980.

	15-19				15-17				18-19			
	Ethnicity		Race		Ethnicity		Race		Ethnicity		Race	
State	Hispanic	Non-Hispanic	White	Black	Hispanic	Non-Hispanic	White	Black	Hispanic	Non-Hispanic	White	Black
Arizona	59	28	26	109	47	21	20	93	83	39	36	132
California	47	24	24	77	32	17	17	55	72	35	36	112
Colorado	52	17	20	72	40	13	15	53	75	24	27	99
Florida	14	37	14	116	10	29	10	94	20	51	21	153
Illinois	45	34	16	116	31	26	12	90	71	48	23	157
New Jersey	49	23	12	93	34	16	8	68	76	34	18	134
New Mexico	26	29	22	50	18	20	15	38	40	45	34	69
New York	49	21	14	69	34	15	10	50	75	30	20	101
Texas	27	29	17	91	21	23	13	75	39	39	25	117
All 22 Reporting States (2)	40	28	(3)	(3)	28	21	(3)	(3)	61	39	(3)	(3)
National Rate(4)	na	na	16	89	na	na	12	70	na	na	24	120

1) States which reported more than 5000 Hispanic births
2) Only 22 states report Hispanic origin of mother on the birth certificate
3) The average rates for whites and blacks for the 22 states are not available.
4) The total U.S. population
5) Births per 1000 unmarried women

Source: U.S., Dept. of Health and Human Services, National Center for Health Statistics, "Birth and Fertility Rates for States, 1980," Vital and Health Statistics, Series 21, No. 42, Table 7 pages 26-27 and Table 4, pages 18-21

Table 12 - Number of children born per 1000 teenagers by ethnicity and race,
at ages 15-19, 15-17, 18-19, selected states, 1980

	15-19				15-17				18-19			
	Ethnicity		Race		Ethnicity		Race		Ethnicity		Race	
State	Hispanic	Non-Hispanic	White	Black	Hispanic	Non-Hispanic	White	Black	Hispanic	Non-Hispanic	White	Black
Arizona	520	280	300	620	210	99	108	297	314	174	186	316
California	425	220	255	445	156	75	87	180	266	140	164	264
Colorado	445	215	240	455	177	69	81	180	270	138	150	264
Florida	205	305	215	630	69	117	69	291	138	182	140	338
Illinois	455	270	205	610	156	102	66	273	288	164	138	334
New Jersey	370	160	115	485	144	57	36	207	226	104	82	282
New Mexico	340	375	330	535	129	135	123	246	210	238	208	284
New York	325	155	130	370	129	54	42	153	198	100	86	220
Texas	490	335	340	560	198	126	126	252	294	200	208	302
22 Reporting States	410	260	205	525	156	96	66	231	254	160	136	294

Source: Table 10.

Table 13: Percent of mothers who had inadequate prenatal care(1) by ethnic origin, Results for 22 Reporting States, 1980 and 1981

			HISPANIC					
Year	All Ethnic Groups	All Non-Hispanic	Total	Mexican	Puerto Rican	Cuban	Central & South	Other/ Unknown Hispanic
1980	5.8	4.9	12.0	11.9	16.2	3.8	13.2	9.2
1981	5.9	4.9	11.6	11.6	15.8	4.2	12.4	8.3

(1) Prenatal care is generally considered inadequate if it is begun after the sixth month of pregnancy or if no visits are made at all

Source: Ventura, S. "Births of Hispanic Parentage 1980" and "Births of Hispanic Parentage, 1981," NCHS, Monthly Vital Statistics Report, Vol 32 (6), 1983 and Vol 33 (8), 1984.

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Table 14 - Percent of adolescent mothers who had inadequate prenatal care(1)

			Non-Hispanic	
	All Mothers	Hispanic	Black	White
1980, National Natality Survey (1)				
< 20				
Total	9.8	11.9	12.8	8.3
Married	5.0	6.5	7.8	4.6
Unmarried	14.8	20.3	13.6	15.3
1981, 22 Reporting States (2)				
15-19	11.6	16.1	13.9	9.0
< 15	21.5	22.7	18.3	26.1
15-17	13.6	17.1	15.2	11.3
18-19	10.5	15.5	12.8	7.9

(1) Prenatal care is generally considered to be inadequate if it is begun after the sixth month of pregnancy or if no visits are made at all.

Source: 1980: Alan Guttmacher Institute, tabulations from the National Natality Survey
1981: Ventura, S., "Births of Hispanic Parentage, 1981", Monthly Vital Statistics Report Vol 33 (8) Supplement; Dec. 1984

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FIGURE 1. Percentage of women aged 15-19 who ever had sexual intercourse, and the percentage who are currently exposed to the risk of unintended pregnancy (based on the National Survey of Family Growth, 1982).

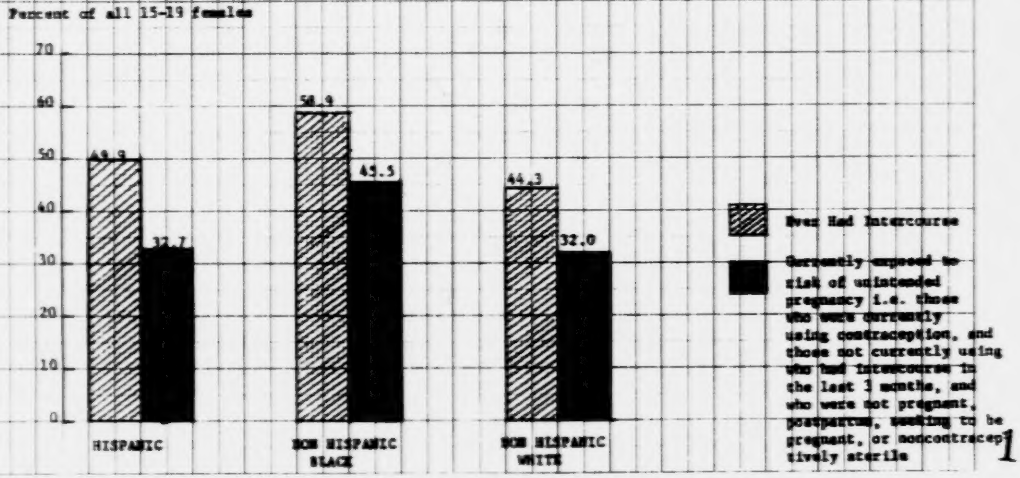

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FIGURE 2. FERTILITY RATES AT 15-19: HISPANIC AND WHITE RATES AS A PERCENT OF BLACK RATES (black rate shown as 100%).

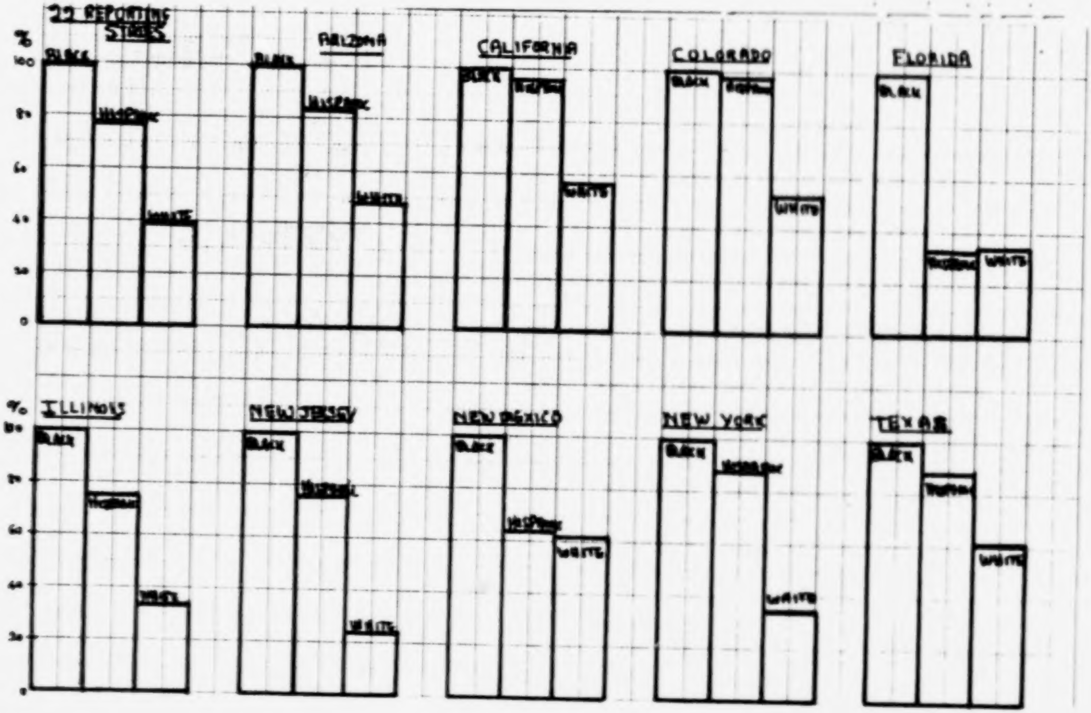

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FIGURE 3. Fertility rate of 15-17 year-olds superimposed on rate of 18-19 year-olds, for comparison, showing 15-17's percent of 18-19 rate.

(Rates are births per 1000 teenagers in 1980)

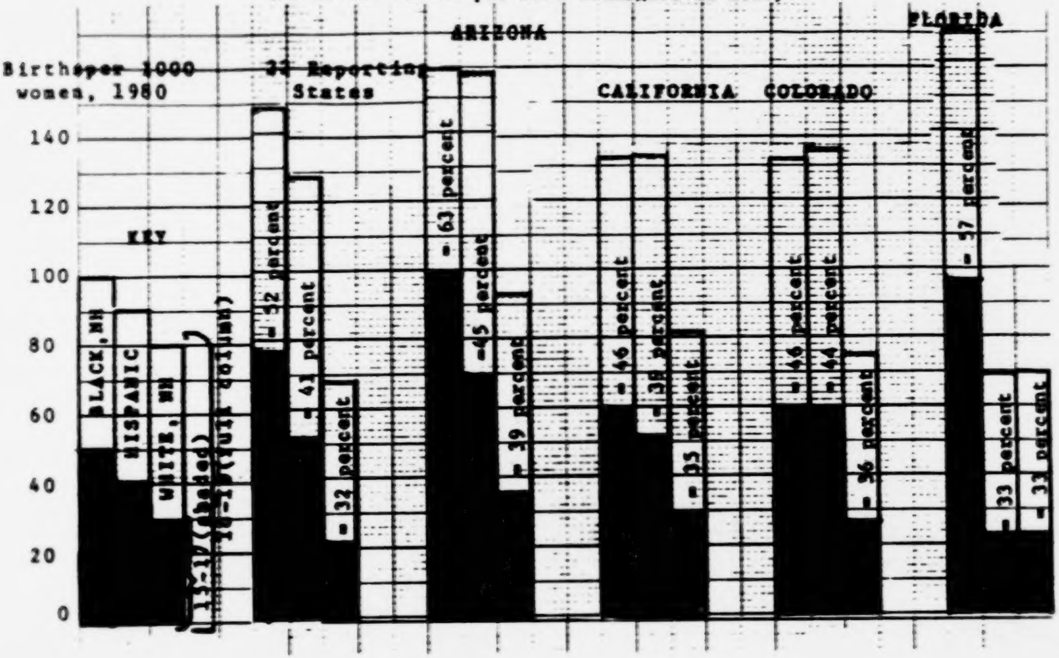

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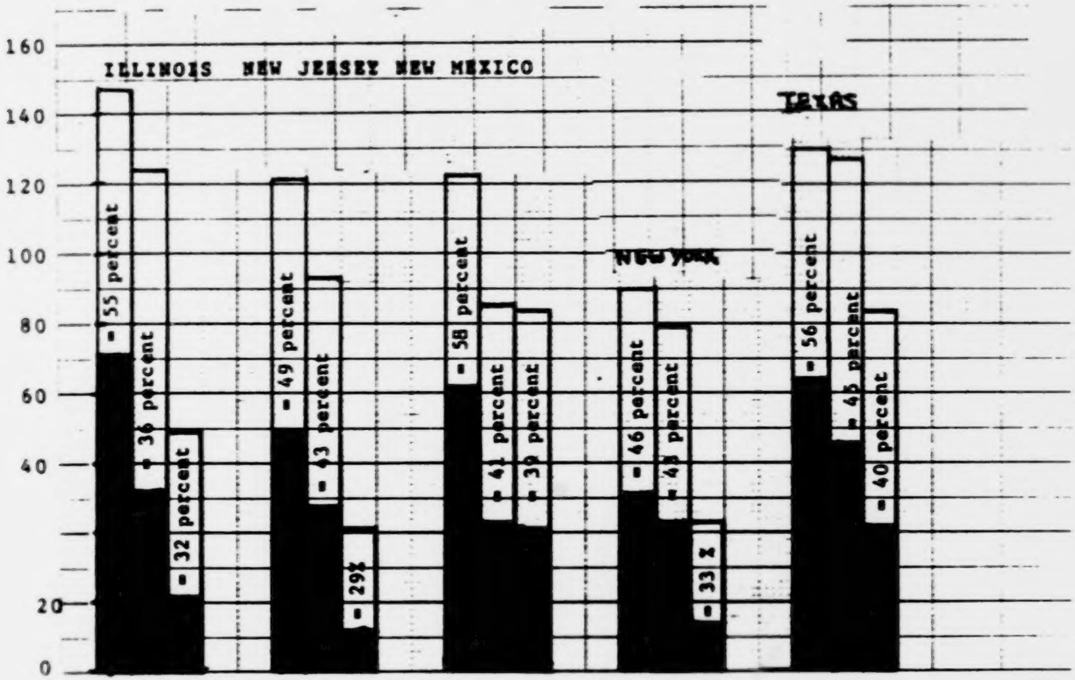
FIGURE 3.-- Continued



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